The Journal

of the Michigan State Medical Society

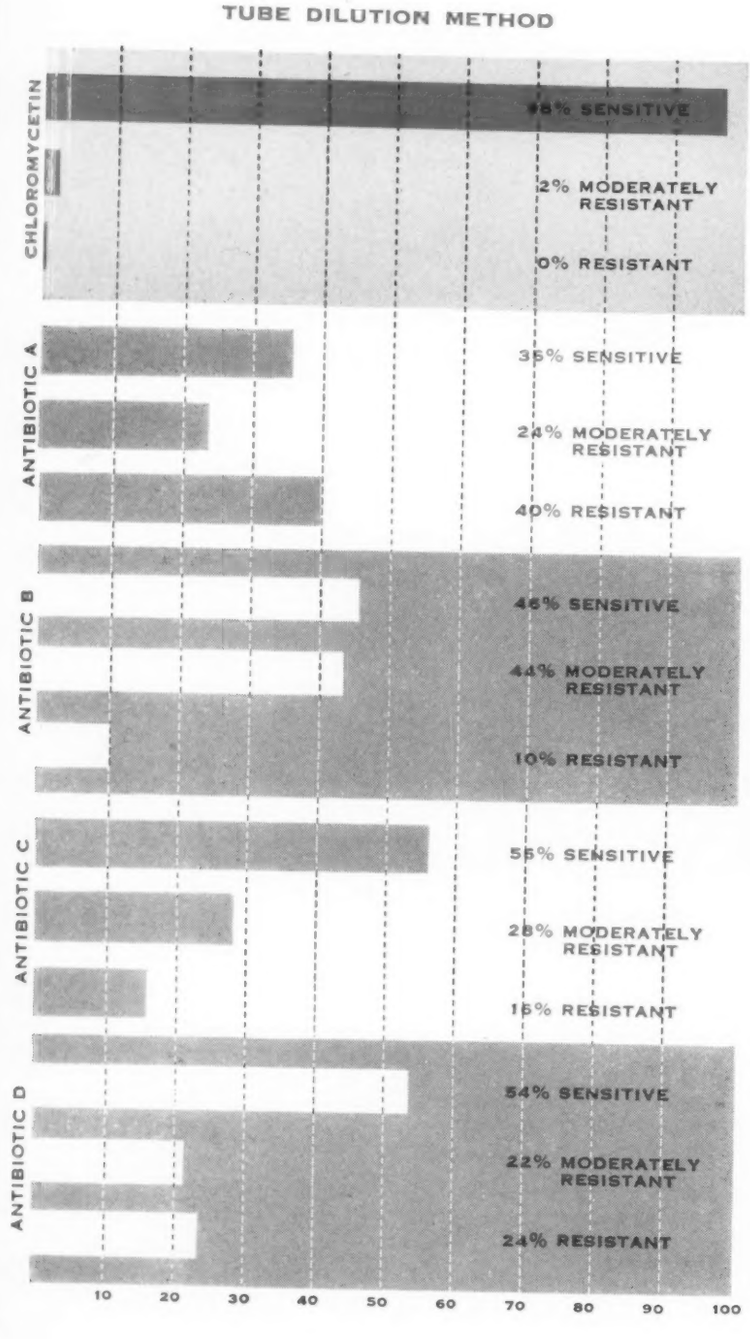
December, 1955

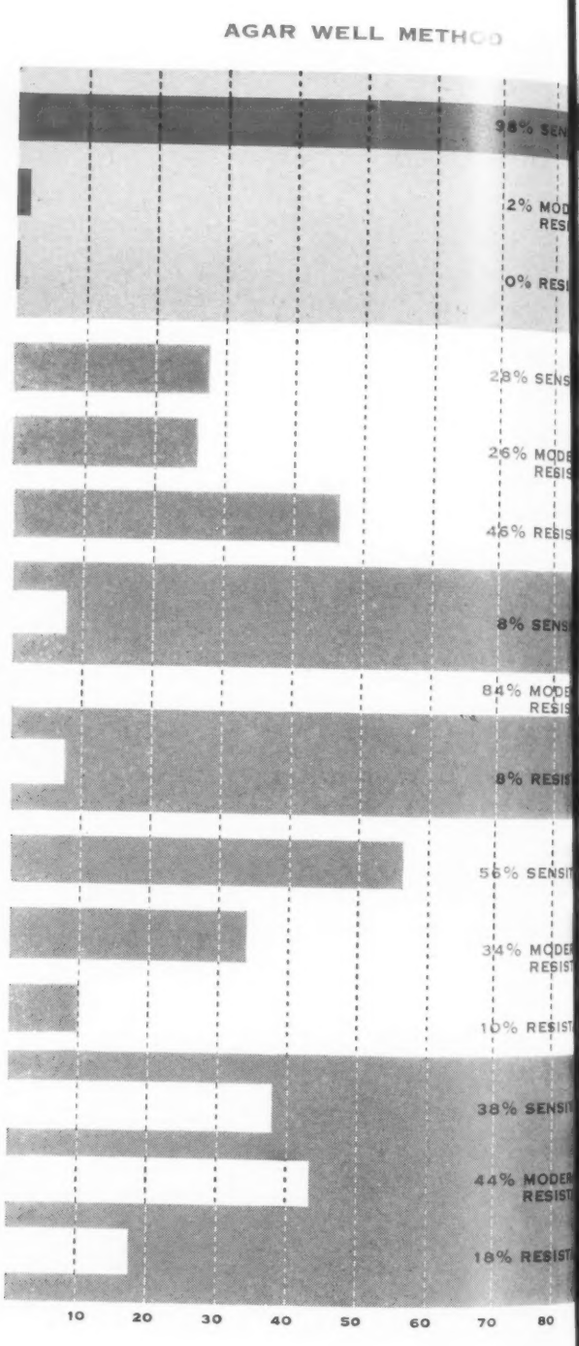
Volume 54

Number 12

more frequently prescrit r

Sensitivity of 50 Coagulase-Positive Staphylococci to CHLOROMYCETIN and Four Other Major A sted by





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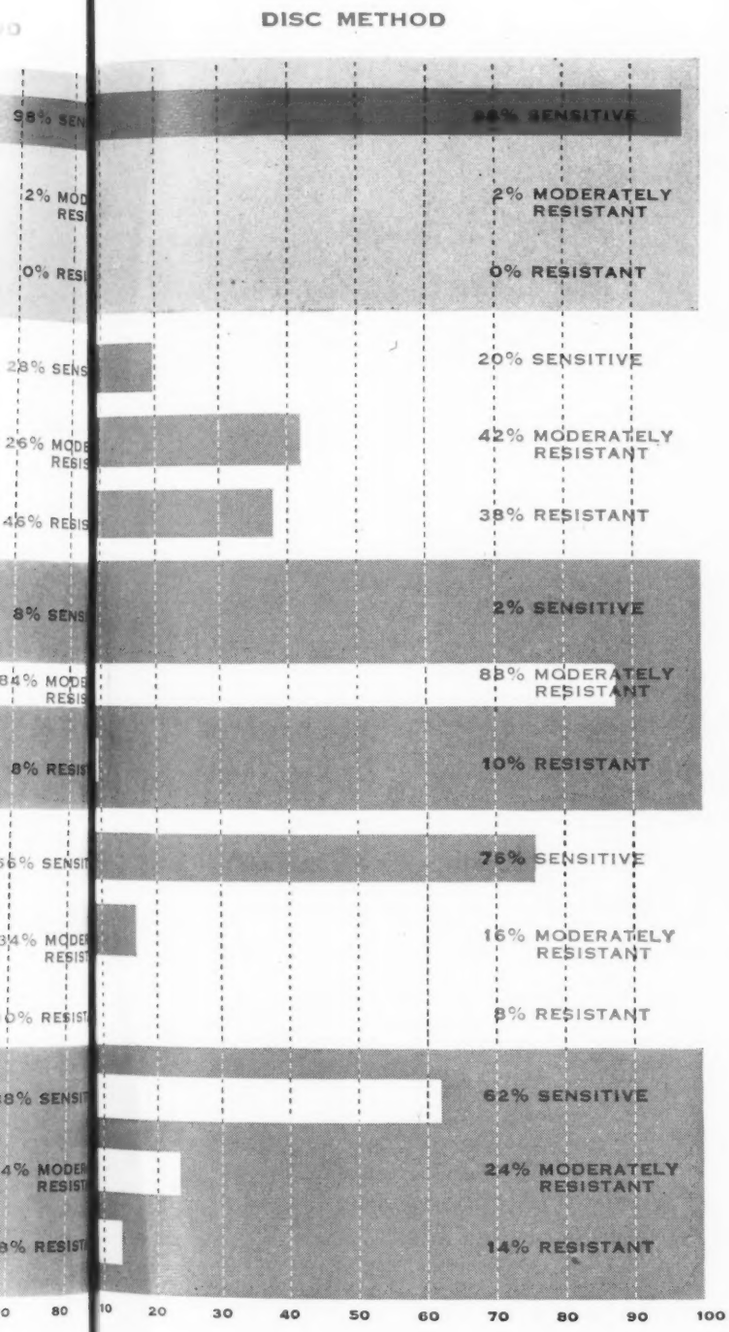

pted from Branch, Starkey, Rogers & Power[6]

Chloromycetin

for today's problem pathogens

The increasing incidence of infections due to antibioti resistant staphylococci poses a major clinical problem.[1-] This is true even when recently introduced antibioti agents are employed.[2,3,5] Recent laboratory investiga tions, however, show that development of staphylococ cic resistance to CHLOROMYCETIN (chloramphenico Parke-Davis) is seldom encountered,[3,6-8] In fact CHLOROMYCETIN "...is being used increasingly i staphylococcic infections resistant to other antibiotics.'

CHLOROMYCETIN is a potent therapeutic agent and, becaus certain blood dyscrasias have been associated with its admini tration, it should not be used indiscriminately or for minor infe tions. Furthermore, as with certain other drugs, adequate bloc studies should be made when the patient requires prolonged intermittent therapy.

References: (1) Spink, W. W.: *Arch. Int. Med.* **94**:167, 1954. (2) Fi land, M.: *J.A.M.A.* **158**:188, 1955. (3) Tebrock, H. E., & Young, W. N *New York J. Med.* **55**:1159, 1955. (4) LeMaistre, C.: *M. Clin. Nor America* **39**:899, 1955. (5) Kagan, B. M.: *J.M.A. Georgia* **44**:210, 19 (6) Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E., Welch, H., & Marti-Ibañez, F.: Antibiotics Annual, 1954-1955, N York, Medical Encyclopedia, Inc., 1955, p. 1125. (7) Kutscher, A. I Seguin, L.; Lewis, S.; Piro, J. D.; Zegarelli, E. V.; Rankow, R., & Sega R.: *Antibiotics & Chemother.* **4**:1023, 1954. (8) Weil, A. J., & Stemp B.: *Antibiotic Med.* **1**:319, 1955. (9) Jones, C. P.; Carter, B.; Thom W. L., & Creadick, R. N.: *Obst. & Gynec.* **5**:365, 1955.

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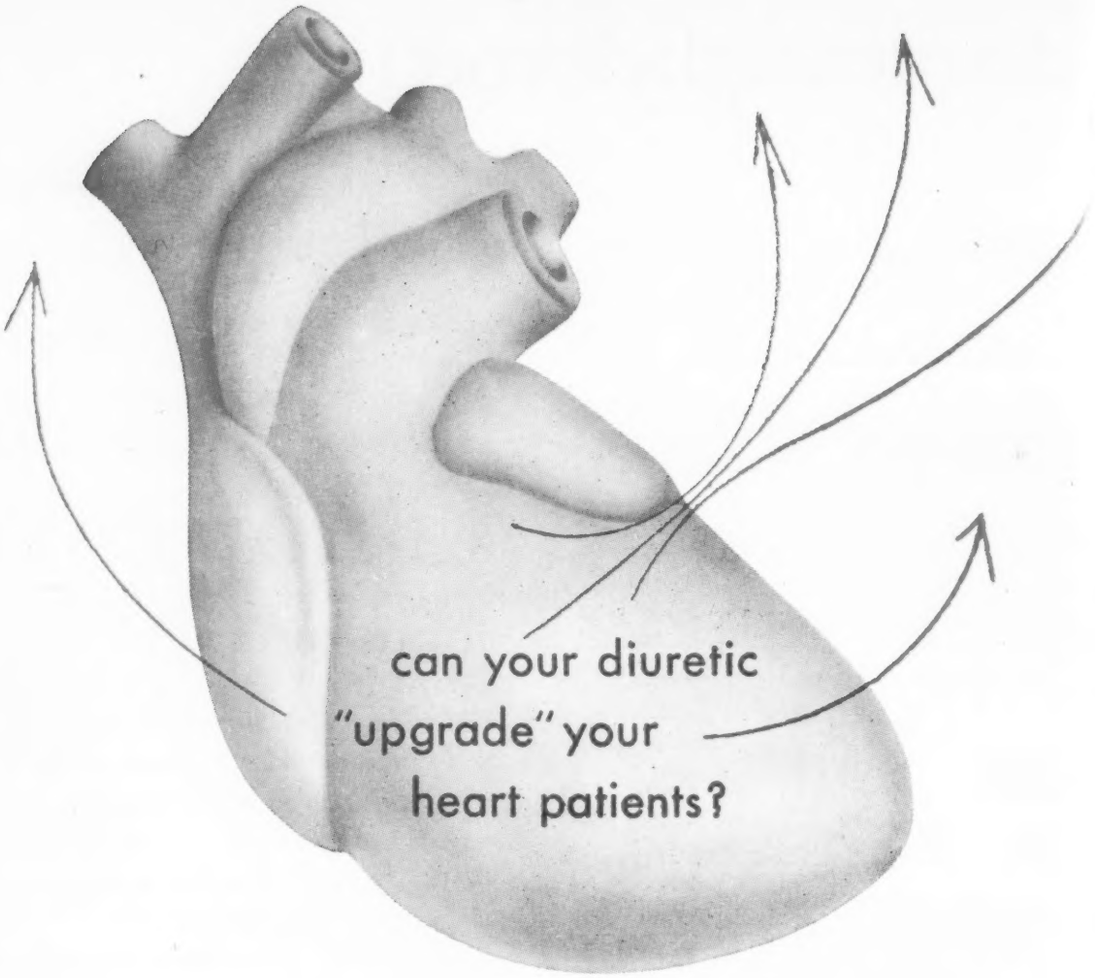

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THE JOURNAL
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You and Your Business

MICHIGAN MEDICAL SERVICE ELECTS NEW OFFICERS

Wilfrid Haughey, M.D., of Battle Creek, Editor of THE JOURNAL MSMS since 1942, has a new job, that of President of Michigan Medical Service. Stepping up with Dr. Haughey is L. Fernald Foster, M.D., Bay City, who replaced Dr. Haughey as Vice President of Blue Shield.

WILFRID HAUGHEY, M.D.

L. FERNALD FOSTER, M.D.

Dr. Haughey succeeds Robert L. Novy, M.D., of Detroit, who resigned as Blue Shield President after thirteen years' service. The election was held October 12. Dr. Haughey is one of the pioneers in prepaid medical care plans and has been a member of the Blue Shield Board of Trustees since Michigan Medical Service was established in 1940. He has practiced medicine in Battle Creek since 1906.

Dr. Foster, a pediatrician, completing his twentieth year as Secretary of MSMS, is another of the Blue Shield pioneers, having been active in establishing Blue Shield and serving on its Board of Trustees since the corporation was founded.

Robert H. Baker, M.D., of Pontiac, immediate Past President of MSMS, was re-elected as Secretary of Michigan Medical Service and Waldo I. Stoddard, Grand Rapids bank executive, returned as Treasurer.

NEW—FIT TO USE

"All That's New and Fit to Use" tells the story of the 1956 Michigan Clinical Institute, to be held March 7-8-9. That's the theme which has been selected by the Committee on Arrangements under the chairmanship of L. W. Hull, M.D.

Once again, the emphasis is on "new" and "use," for the program has been laid out to present Michigan doctors of medicine, and their colleagues from nearby states, with the very latest in medical progress that can be used every day in their office and in the hospitals.

"We are certainly proud of the many headliners that have accepted our invitation to be on the MCI program," Dr. Hull said. "We think it is the greatest scientific program ever lined up for any MCI."

The entire three-day meeting is aimed at the private practitioner who wants to hear the newest information, and see the results of the latest research, presented by really top-level lecturers and clinicians. Altogether, thirty outstanding doctors are scheduled to appear in the six meetings planned during the MCI. There is every indication that the 1956 MCI will top all previous sessions in its interest, subject matter, and quality of presentation.

Now, Doctor, is the time to arrange your schedule to attend the 1956 Michigan Clinical Institute at the Sheraton-Cadillac Hotel, Detroit, March 7-8-9, 1956. Write directly to the Sheraton-Cadillac Hotel for reservations, addressing your request to the Committee on Hotels, Michigan Clinical Institute, Miss Dorothy J. Gibb, Secretary.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 19, 1955

Seventy-two items were presented to the Executive Committee of The Council at its October 19 meeting in Lansing. Items of chief importance were:

- **C. D. Selby, M.D., Port Huron,** and **Orlen J. Johnson, M.D.,** Bay City, were appointed Chairman and Secretary, respectively, of the new Section on Occupational Health, created by the 1955 MSMS House of Delegates.
- **A Special Committee to Improve Officers' Night Ceremonies** was appointed by Council Chairman D. Bruce Wiley, M.D.: L. Fernald Foster, M.D., Bay City, Chairman; R. H. Baker, M.D., Pontiac; William A. Hyland, M.D., Grand Rapids; W. S. Jones, M.D., Menominee; and Arch Walls, M.D., Detroit.
- **A suitable memento** for R. L. Novy, M.D., Detroit, retired President of Michigan Medical Service, was authorized, and the Chairman was empowered to select the gift.
- **Financial Reports** were presented, given study, and approved. Bills payable were approved and payment was authorized.
- **Committee Reports:** The following committee reports were presented—(a) Committee on Study of Cancer Quackery (appointed by President W. S. Jones, M.D., on instruction of 1955 House of Delegates), meeting of October 14;

(Continued on Page 1408)

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1406)

(b) Michigan Cancer Co-ordinating Committee, October 14; (c) Committee on Hospital Pharmacy Operation (a committee of the Michigan Hospital Association), October 14.

- **Walter S. Stinson, M.D.,** Bay City, was appointed as Councilor of the Tenth District for the unexpired term (1957) of Fred H. Drummond, M.D., retired. Commendation on the excellent work of Dr. Drummond during the last decade and his service to Medicine in Michigan, were made a matter of record in The Council minutes.
- **A joint meeting** with the Executive Committee of the Board of Commissioners, State Bar of Michigan, was held, and matters of mutual interest were discussed, including medicolegal testimony (Minnesota Plan) and the Interprofessional Code of Wisconsin. The State Bar representatives suggested the creation of a joint committee, of three lawyers and three doctors of medicine, to study the possibility of drafting an interprofessional guide between medical witnesses and lawyers for the State of Michigan.
- **1959 MSMS Annual Session:** The dates of September 28-29-30 and October 1-2 were set for the Grand Rapids Annual Session of 1959.
- **Lester E. Bauer, M.D.,** Detroit, was appointed Discussion Conference Leader for the Michigan Clinical Institute Session of Friday, March 9.
- **Liaison Committee with State Executive Office:** W. S. Jones, M.D., Menominee, was appointed Chairman, with the following committee personnel: Robert H. Baker, M.D., Pontiac; L. Fernald Foster, M.D., Bay City; B. M. Harris, M.D., Ypsilanti; K. H. Johnson, M.D., Lansing; Ralph W. Shook, M.D., Kalamazoo, and D. Bruce Wiley, M.D., Utica.
- **1956 MSMS Annual Session and University of Michigan Triennial Medical Alumni Reunion Dates.** Suggestion from Dean A. C. Furstenberg, M.D., Ann Arbor, concerning next year's Triennial Reunion, which will coincide on two of the three Annual Session dates was adopted. The MSMS dates will be Wednesday-Thursday-Friday, September 26-27-28, in Detroit; the Triennial Medical Reunion dates will be Thursday-Friday-Saturday, September 27-28-29, in Ann Arbor.
- **B. L. Masters, M.D.,** of Fremont, was chosen as MSMS representative to the Michigan Health Council, in lieu of John R. Rodger, M.D., Bellaire, resigned.
- **Appointment of Committees of The Council,** as made by Council Chairman D. Bruce Wiley, M.D., were confirmed.
- **Legal Counsel J. Joseph Herbert** rendered opinions on several matters including inquiry re a physican participating as a stockholder in a proposed corporation; and re capacity and competence to make wills.
- **New Michigan Medical Service Officers:** Report was given that Wilfrid Haughey, M.D., long-time Editor of JMSMS, recently was elected President of Michigan Medical Service; L. Fernald Foster, M.D., Bay City, was chosen as Vice President.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physician groups in Michigan, follows:

1956		
January 18-21	Michigan Rural Health Conference	Kalamazoo
January 22-24	Industrial Health Conference, AMA, Sheraton-Cadillac Hotel	Detroit
January 25-27	Annual Meeting of the MSMS Council, Sheraton-Cadillac Hotel	Detroit
January 27-29	MSMS County Secretaries-Public Relations Seminar, Sheraton-Cadillac Hotel	Detroit
February 16	MSMS Executive Committee of The Council	Detroit
March 6	Michigan Chapter, American College of Surgeons	Detroit
March 7-9	Michigan Clinical Institute, Sheraton-Cadillac Hotel	Detroit
March 9	MSMS Executive Committee of The Council	Detroit
Spring	MSMS Postgraduate Extramural Courses	Statewide
April 11	Genesee County Medical Society's Eleventh Annual Cancer Day	Flint
April 18	MSMS Executive Committee of The Council	Lansing
May 3	Twenty-Eighth Annual May Clinic, Ingham County Medical Society	Lansing
May 8-9	Annual Clinic Day and Alumni Reunion, Wayne University College of Medicine	Detroit
May 16	MSMS Executive Committee of The Council	Detroit
June 4-7	American Cancer Society, Sheraton-Cadillac Hotel	Detroit
June 11-15	Annual Session, American Medical Association	Chicago
June 20	MSMS Executive Committee of The Council	Muskegon
June 22-23	Upper Peninsula Medical Society	Sault Ste. Marie
July 19-21	Mid-summer Session of the MSMS Council	Mackinac Island

Cancer Comment

CANCER CONTROL

While reviewing cancer progress, the writer has been impressed by the conclusions of some of the vast number engaged in research in this disease.

Noteworthy is that portion of the report of the Director of the Sloan-Kettering Institute, titled:

Steps Toward Cancer Control

1. The diagnosis of early cancer of certain sites has been improved by better means of defining the presence of cancer cells in fluids from the prostate gland, lung, and uterus.

2. An electronic device has been contrived which perhaps in time will automatically detect in body fluids cells which might be cancer.

3. Promising leads have been found toward the development of a blood test for cancer, but final success has not yet been achieved.

4. A chemical method has been discovered that aids in the diagnosis of heart attacks due to closure of the coronary arteries, one of the most frequent causes of death from heart disease. This test is also very sensitive in detecting acute damage to liver cells.

5. A chemical has been prepared that dissolves clots in both the veins and arteries of experimental animals. It can be administered safely to human beings, but final proof of its ability to dissolve these often fatal clots in man is not yet available.

6. The cause has been disclosed of the digestive difficulties which follow, and limit the usefulness of, operations to cure cancer of the stomach, and some means for their control devised.

7. More information has been gained and more effective control devised for certain complications of surgery due to chemical disturbances in the body.

8. New procedures have been devised for measuring exactly the amounts of ionizing radiation delivered to particular areas of the body and so to make radiation treatment for cancer more precise.

9. Accurate methods applicable to patients have been developed for defining the control by body chemistry (hormones) of the growth of some types of cancer.

10. The existence has been proved of two types of cancer of the breast requiring different procedures for their temporary chemical control.

11. Cortisone has been proved to restrain temporarily the growth of breast cancer in certain patients.

12. An effective chemical treatment of formerly uncontrollable tumors of small blood vessels has been devised.

13. Differences have been disclosed in chemical compounds as released by normal and cancerous thyroid tissue.

14. New knowledge of the action of pituitary hormones on various organs has been acquired, particularly as they may induce or stimulate growth of breast cancer.

15. Temporary restraint of progressive cancer of the breast or of the prostate gland has been achieved in a few patients by the removal of the pituitary gland.

16. New procedures have been discovered for the more accurate evaluation of the ability of new drugs to control pain in cancer patients.

17. Improved and reliable methods for measuring minute amounts of metals in normal and cancer tissue are yielding unexpected and significant new information.

18. Further new information has been achieved concerning different requirements of human normal and cancer cells for the chemicals they use for reproduction and growth.

19. Several types of human cancer have been grown in the test tube.

20. Several viruses have been found to invade and parasitize human cancer growing in the test tube.

21. The ability of one virus to destroy human cancer cells of one type in the test tube has been enormously enhanced, and the same time its injurious effect on animal normal tissue has decreased.

22. Four strains of human cancer are now in mass cultivation in animals, in tissue culture, and in incubated fertile eggs and are being distributed to other laboratories.

23. New information has been gained on the minute chemical structure of the compound that governs inherited characteristics and is believed to be the key to cancer growth.

24. Test tube methods of greatly increased sensitivity and accuracy have been devised and employed to define the ability of certain chemicals selectively to injure cancer as compared with normal cells.

25. The techniques of electron microscopy have been greatly improved for the study of normal as compared with cancer tissue. Incredibly minute details of cellular structure have been revealed.

26. Two new pure chemicals have been synthesized and several impure ones prepared which strongly restrain the growth of animal cancer.

27. Chemicals capable of curing several different types of transplantable animal cancer have been discovered.

28. A chemical, 6-mercaptopurine, has been discovered in collaboration with Wellcome Research Laboratories and appears to be one of the most effective in restraining acute leukemia in children and adults.

29. New information has been obtained which suggests circumcision as a practical means for the prevention of cancer of the cervix in women.

30. Data have been accumulated on the incidence of precancerous changes of the large intestine, and studies are in progress to evaluate their significance.

31. An extensive co-operative effort has been established to define the constituents of cigarette smoke that have been proved to cause cancer in animals.

32. A method of growing normal embryonic human lung and other normal human tissue in experimental animals has been devised.

33. Improved new and reliable procedures have been developed for defining and measuring the production of hormones of the sex and adrenal glands and the changes they undergo in the body.

34. Correlations have been suggested between deviations in hormone production and alterations in the normal physiology of human subjects.

35. The delay of leukemia in experimental animals prone to that disease has been achieved by chemical.

36. A wholly new, basic scientific principle of biochemistry that should permit the selective injury of almost any desired type of body cell has been discovered.

(Continued on Page 1412)

CANCER CONTROL

(Continued from Page 1410)

These steps have been achieved by the expenditure of time and effort by many-many scientists and research staffs. This is convincing evidence indicative of progress in the cancer field.

Apart from the scientific development those in the research field have some interesting statistics.

Statistical Facts

1. Cancer will at some time strike one in every four Americans, according to present estimates.
2. It is estimated that more than 40,000,000 Americans now living will at some time develop cancer.
3. Out of every seven deaths in the United States, one is caused by cancer.
4. If present death rates continue, 24,000,000 Americans now living will die of cancer.
5. On the average, cancer strikes about two out of every three American families.
6. Every day approximately 650 Americans die of cancer.
7. There is one cancer death approximately every two minutes in the United States.
8. Last year, every seven minutes, on the average, another American was saved from dying of cancer.
9. Every seven minutes, on the average, another American who might have been saved dies of cancer because proper treatment was begun too late.
10. This year, more than 235,000 Americans will die of cancer.
11. It is estimated that this year more than 700,000 Americans will be under medical care for cancer.
12. It is estimated that this year there will be about a half million new cancer cases in the United States (cases diagnosed for the first time).
13. It is estimated that there are about 400,000 persons living in America who were saved from cancer at least five years ago.
14. Last year, perhaps 75,000 Americans were saved from dying of cancer.
15. Last year, more than 230,000 Americans died of cancer.
16. Last year, perhaps 75,000 cancer patients who might have been saved died because proper treatment was begun too late.
17. Last year, more men than women died of cancer. (This has been true since 1949.)
18. Last year, cancer took the lives of some 3,000 children (under fifteen years of age.)
19. Last year, cancer of the lung killed approximately 24,000 Americans, about seven times as many as in 1933.
20. At present rates, of every four people who get cancer, one will be saved, and three will die of the disease.
    - (A) One will be saved from cancer.
    - (B) One will die needlessly because with present knowledge he could be saved.
    - (C-D) Two will die because their cancers are of the types that science has not yet the tools to cure. However, in many cases, much can be done to ease their pain and prolong their useful lives.
21. About one-half the deaths from cancer in the United States are in those people under sixty-five years of age.
22. In the United States cancer today kills more children from three to fifteen years of age than any other disease.
23. In the United States there are about 160,000 children under the age of eighteen who have lost their fathers from cancer, and about 175,000 who have so lost their mothers.

Pituitary Hormone Role

In May of this year at a medical meeting in Atlantic City, Doctors of the Memorial Hospital and Cornell Medical Center, New York Hospital Groups reported that widespread breast cancer can be temporarily controlled by an operation to remove the pituitary gland at the base of the brain.

Of forty-three women with advanced breast cancer in whom the pituitary gland was removed twenty showed marked improvement, seventeen were considered failures and six were treated too recently to be evaluated. Fifteen of the twenty improved patients are still in remission at the present time. The longest remission to date has been twenty months.

Cancers of the breast that could not be removed by operation shrank, as did cancers that had spread to bone, bone marrow, lung, brain, spinal cord and skin. Patients were able to walk again, to breathe more easily and to return to normal activities. Bones broken because the cancer had destroyed bone tissue healed again. Patients felt good generally.

The results of the treatment, besides the new, if temporary, lease on life given the patients, suggest that hormones of the pituitary gland may play a hitherto unsuspected role in the growth of some kinds of cancer.

The Second Look Suggestion

Recent reports from one of the well-known and highly regarded clinics in the Midwest has stirred widespread interest in the second look concept.

Re-operations to remove asymptomatic, residual cancer of the stomach, rectum, or colon with lymph-node metastases are performed. Six months after the original operation with no clinical evidence of residual cancer, a second operation is performed and any residual cancer found is removed, if possible. If cancer is found at this second-look operation, third and fourth operations are carried out subsequently at similar intervals of time until no more cancer is found. In some of the one hundred twenty-four patients who had gastric, colic, or rectal cancers with lymph node involvement, further exploratory operations were performed after the second-look operation, so that in all, one hundred and seventy-five operations were done after the original one. Six patients with residual cancer at the second operation were finally found to be free from cancer at some subsequent operation. They are still alive and have no evidence of residual cancer. One of the six patients had cancer of the stomach; one, cancer of the rectum; and four, cancer of the colon. The second-look seemingly has greater promise in patients with colon cancer. The authors feel that sufficient time has not elapsed to establish or disprove their assumption that residual abdominal cancers may

(Continued on Page 1486)

for equanimity [1,2] . . .

new anti-anxiety factor with muscle-relaxing properties relieves tension

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Usual dosage: 1 tablet, t.i.d.

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AMA Washington Letter

THE MONTH IN WASHINGTON

If advance signs mean anything, the Eisenhower Administration next year can be expected to ask Congress for substantially more money for medical research, both direct research by scientists on the U. S. payroll and grants to others.

Currently the federal government is spending more money on medical research than at any time in history—almost $98 million through the National Institutes of Health alone. In addition other millions are being spent on medical research in the Department of Defense, Veterans Administration and other agencies. Much of it is difficult to isolate in the federal budget.

A special committee named by the National Science Foundation at the request of former Secretary Hobby has been at work for some time on an appraisal of HEW's medical research programs. Its report, due before the reconvening of Congress, should be valuable to both the administration and the appropriations committees.

A few examples of what is happening this year:

National Cancer Institute has $24.8 million to spend, about three million more than last year, with two-thirds going out in grants to non-federal researchers. National Heart Institute also is working on a much more liberal budget, $18.7 million in contrast to last year's $16.6 million. Because of the spectacular publicity now being given to heart research as a consequence of President Eisenhower's illness, it is a foregone conclusion that next year this institute will get a great deal more money.

The Mental Health Institute is profiting by the largest single increase of any research operation, almost $4 million, from $14.1 to $18 million. Here again the prospects are for a substantial increase next year; problems of mental health are receiving much public attention, a situation that will not be ignored by Congress. Furthermore, the nationwide survey of mental health problems now about to get under way will point up the shortcomings in mental health research, and be an additional argument for more U. S. dollars.

All the other research institutes also shared in last session's Congressional generosity. The Institute of Arthritis and Metabolic Diseases has about $2.5 million more, $10.7 million instead of the $8.2 million of last year. The Institute for Neurological Diseases and Blindness went from $7.6 million to $9.86 million, the Microbiological Institute from $6.1 to $7.5 million, and the Dental Health Institute from $1.9 to $2.1.

As has been customary with recent Congresses Senate and House this year actually voted more money for medical research than the Bureau of the Budget permitted Public Health Service to request. That may not be the situation when appropriation bills come up next session. Secretary Folsom of the Department of Health, Education and Welfare did not take office until Congress was about to adjourn last summer, but since then he has repeatedly gone on the record in favor of even greater U. S. expenditures for research. In October Mr. Folsom declared:

". . . Today we find new problems and new opportunities. We find that heart disease, and cancer and arthritis, are taking an increasing toll. And so today as a nation we are changing our lines of battle to fight this increase in chronic and major diseases. All the facts point to one great need. It is the need for more research—to learn how these chronic diseases are started, so they can be prevented; to learn to detect them in the early stages, so they can be cured. . . ."

Again in November, addressing a conference on antibiotics, Mr. Folsom struck the same key, only this time more firmly. After noting that the U. S. now is spending over twelve times more on medical research than it was spending in 1946, he declared: "We must seriously consider making even more funds available for medical research to bring even greater benefits to humanity."

Notes

The Joint Congressional Committee on the Economic Report may have some health legislation to offer next year as a result of a study of the problems of the low-income family, including methods of paying hospital, physician and drug bills.

The medical and criminal problems connected with narcotic addiction have occupied the attention of two Congressional groups between sessions. subcommittees of the Senate Judiciary Committee and the House Ways and Means Committee. The latter is particularly worried over abuses it claims to have discovered in the use of barbiturates and amphetamines.

Dr. Frank B. Berry, assistant Defense Secretary for Health and Medical matters, in his annual report warns that the doctor procurement problem again may become acute, despite last summer's two-year extension of the act. He said the Department may not be able to obtain all the older physicians it needs because of the amendment barring the drafting of men over thirty-five if they have applied for a medical commission and been rejected on purely physical grounds. Also, Dr. Berry thinks the ratio of three physicians per 1,000 of troops may be too narrow a margin for safety.

in rheumatoid arthritis

• 4-5 times as potent as cortisone or hydrocortisone, mg. for mg.

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PREDNISOLONE, SCHERING

METICORTELONE resembles METICORTEN in antirheumatic, anti-inflammatory and antiallergic effectiveness.[1-11] The availability of these new steroids, first discovered and introduced by Schering, provides the physician with two valuable agents of approximately equal effectiveness in cortical hormone therapy.

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Schering

METICORTELONE,* brand of prednisolone, Schering.
METICORTEN,* brand of prednisone, Schering.
*T.M.

ML-J-55

PR REPORT

R. N. PHILLEO IS MSMS FIELD SECRETARY—The PR staff has been brought up to full strength with the appointment in October of Richard N. Philleo of East Lansing as Field Secretary.

MR. PHILLEO

Mr. Philleo, or Dick as he prefers to be known, long has been active in legislative and political work. He has worked in the House of Representatives for many sessions and has a keen knowledge of the "legislative process." He is a member of East Lansing's Traffic Commission.

He attended MSU prior to his enlistment in the USAAF in 1942. During World War II, he served as a bombardier with the 8th Air Force in Europe, climaxed by eight months as a prisoner of war in Germany.

Dick is married and has two sons, Steve and Dave. Outside interests, beside politics, include photography and flying. He is a member of Lansing Lodge F. and A.M. 33.

His appointment fills the vacancy created in July by the death of Stuart A. Campbell of Grand Rapids.

SPECIAL SESSION GRINDS TO AN INCOMPLETE STOP—On November 1, after much preliminary study, the Governor called the Legislature into extra session in Lansing for the purpose of considering emergency measures covering three fields, namely: highway safety, teachers' salaries, and care for the mentally retarded children.

At the MSMS Annual Session in September, 1955, the House of Delegates anticipated this action and adopted two resolutions: one, "strongly endorsing the principle of state subsidy of student driver training," and the other recommending immediate action by the Legislature and the Governor to alleviate the mentally retarded children emergency without "impairing . . . the effective tuberculosis control program now in progress." These resolutions were forwarded to members of the Legislature; in addition, the PR staff has been in constant attendance at their daily sessions.

By week's end the members had passed, and the Governor had signed, measures providing for a state-wide speed law (65 m.p.h. days, 55 nights), driver education at local levels in conjunction with a traffic center at MSU, automobile safety belt standards and township licensing control over bicycles. Also agreed upon was a teachers' pay raise.

No agreement could be reached, however, on a program for the mentally retarded, and upon adjournment three days later, both houses were notified of a "second extra session" called for the Monday following, either to settle on (1) the "administration plan" for the lease of the old Fort Custer Station Hospital and purchase of one or both of the Oakland County Sanatorium and the Farmington Hospital, or (2) the "Senate plan" calling for the lease of Fort Custer facilities and the expansion of present facilities at Lapeer, Coldwater, Caro and Mt. Pleasant and "Family Care" and "Contract Patient" programs.

Several weeks later, at the time of going to press, the legislators and the Governor were as far apart as ever.

UNITED STATES BECOMES "MEDICAL MAGNET"

The United States has become a "medical magnet" for physicians in Europe, Asia, Africa, and Latin America.

More than 5,000 foreign physicians came to this country during the year 1954-55 for study, according to a survey by the Institute of International Education and the American Medical Association.

They came from eighty-three different countries for internship and residency training at hospitals in forty-two states, the District of Columbia, Hawaii, Puerto Rico, and the Canal Zone.

The survey of 1,177 hospitals, among those approved for internships and residencies by the AMA Council on Medical Education and Hospitals, indicated that there were at least 5,036 alien physicians in training. Not included in the study were immigrants and displaced persons.

Individual countries sending the most physicians were the Philippines, Canada, Mexico, Germany, and Turkey. Of the major geographical areas, the Middle, Near, and Far East had the largest representation.

Of the total, 620 (12.3 per cent) were women. In comparison, women made up only 5.2 to 5.7 per cent of American medical school graduating classes in the years 1952 through 1954. Over half of the women came from the Near, Far, and Middle East, with the Philippines sending the most.

More than 2,000 of the physicians were in the United States on their own resources. Others were sponsored by at least sixty-seven different agencies, including their own or the United States government, the United Nations, and religious, educational or philanthropic organizations. Many were sponsored by the hospitals in which they were training.

In addition to the large number of physicians in hospital internship-residency training, others visited this country as observers, professors, or guest participants in research. They represented 21.5 per cent of all foreign educators who visited the country during the year.

In comparison, only 3.6 per cent of all American educators visiting other parts of the world in 1954-55 were listed under medicine.

The survey was reported in the August 13 number of *The Journal of the American Medical Association* by Dr. James E. McCormack, associate dean of graduate studies at Columbia University College of Physicians and Surgeons, and Arthur Feraru, head of the Central Index and Census Division, Institute of International Education, both of New York.

The JOURNAL

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Thrombotic Thrombocytopenic Purpura with Associated Afibronogenemia

Report of Case

By Robert C. Dickenman, M.D., Howard J. Brown, M.D., Tomiharu Hiratzka, M.D., and Gunner Vetne, M.D.

Detroit, Michigan

SINCE first described in 1924 by Moschowitz,[9] fifty-five cases of thrombotic thrombocytopenic purpura have been reported. However, several of these may not be true examples of the condition. The syndrome is characterized by hemolytic anemia, thrombocytopenic purpura and variable neurologic manifestations. Recent studies indicate that the basic lesions are multiple aneurysmal dilatations of capillaries and arterioles, irregular segmental amorphous hyaline-like thickenings of the walls of these vessels and proliferation of endothelial cells.[8,10] There is secondary formation of platelet thrombi at some of the involved sites. In addition a few cases have been reported in which there were vegetations on the valves of the heart.[2,3,4,5,8] The literature has been reviewed by Barondess[2] and Symmers[14] in 1952.

This case is presented to describe further the endocardial vegetations and to report a case in which there was afibrinogenemia and thrombosis of large vessels.

From the Departments of Medicine and Pathology, City of Detroit Receiving Hospital and Wayne University College of Medicine.

Report of Case

Clinical Data.—The patient, a thirty-nine-year-old Negress, mother of six children, was admitted to the medical service of Detroit Receiving Hospital on August 2, 1953.

She had been in good health until twelve days before admission when she had experienced a sudden onset of unconsciousness, weakness of the right arm and leg and slurring of speech. She was admitted to another hospital at that time and recovered rapidly. On the day before this admission she developed left hemiplegia and consequently was brought to the hospital.

In 1951 the patient had received x-ray and radium therapy for carcinoma of the cervix uteri. In October, 1952, the pelvic examination was negative except for scarring in the base of the right broad ligament. A mass in the posterior pelvis was demonstrated by intravenous pyelograms; biopsy of the cervix was negative for carcinoma. Treatment for the past eight months had been for swelling of the right leg, thought to be due to old thrombophlebitis.

Admission physical examination revealed a euphoric, obese Negro woman. The blood pressure was 150 systolic, 80 diastolic, temperature 98° F. and other vital signs normal. Head, eyes, ears, nose and throat were normal. There was neither jaundice nor purpura. Chest wall, breasts and lungs were normal. The heart was not enlarged and no murmurs were heard; the rhythm was regular sinus. Examination of the abdomen was negative and the pelvis was unchanged from the above examination. There was paresis of the right seventh nerve, impaired movement of the uvula and palate and weakness of the left arm and leg. The muscle stretch reflexes were equal and hyperactive throughout and the Hoffman's sign was bilaterally positive. The Babinski was negative. The patient was unable to co-operate for a sensory examination.

Laboratory Data.—Urinalysis with a specific gravity of 1.027 was negative. Hemoglobin 10.6 gm./100 ml., the white cell count, 10,000 per cu. mm., and a differential of 68 per cent neutrophiles, 21 per cent lymphocytes, 8 per cent monocytes, and 2 per cent each of eosinophils and basophils. The blood urea nitrogen value was 16 mg./100 ml.; prothrombin time (Quick)

19.7 seconds (control 13.3 seconds). Spinal fluid protein was 4 mg./100 ml.; sugar 48 mg./100 ml., and chlorides 114 mEg./liter. Blood and spinal fluid Kline tests for syphilis were negative.

Because of a history of urinary difficulty two years before, fluctuating neurological signs and euphoria, the initial impression was multiple sclerosis.

The patient's condition remained unchanged, except for occasional vomiting unrelated to eating, until four days before death. Upper and lower gastrointestinal series and cholecystograms revealed no cause for the vomiting. Except for occasional elevations of temperature to 99.2° and 99.6° F. the patient was afebrile. The hemoglobin on August 10 was 10.3 gm./100 ml. and the white count was 18,300 per cu. mm. with a normal differential. Repeat white count on August 14 was 14,300 per cu. mm.

On August 19 the patient had an onset of pain and swelling of the left leg thought to be due to thrombophlebitis. Clotting time by the Lee-White method, after this episode, revealed no clot formation in four hours. Six hours later, in spite of an inadvertently given dose of dicoumarol (150 mg.) and heparin 50 mg., the clotting time was 6 minutes.

The next day, August 20, occlusion of the left femoral artery was noted. The prothrombin time was 20.1 seconds (control 11.2 seconds) and there was no clot formation by the Lee-White method. Later that day the clotting time was four minutes.

On the morning of August 21 there was occlusion of the right brachial artery. Again the blood did not clot by the Lee-White method. The hemoglobin was 8.7 gm. per 100 ml., erythrocyte count 3.7 millions per cu. mm., hematocrit 35 vols. per cent and platelet count 37.000 per cu. mm. Bleeding time was three minutes. The prothrombin concentration was 14 per cent by the Owren method and the prothrombin time 87 seconds by the Quick method. Again in the afternoon the clotting time was four minutes. Total serum proteins were 7.2 gm. per 100 ml. with 4.5 gm. per 100 ml. of albumin. Tests for cryoglobulins were negative.

During the last two days of life, while these thrombotic episodes were occurring, the patient had blood pressures ranging from 70/50 mm. Hg to 0/0 and a temperature elevation up to 101° F. There were still no cardiac murmurs and the electrocardiogram was normal. There was no jaundice or purpura, but the patient did have an emesis of coffee ground material on the last day of life. Attempted ganglionic blocks of the extremities were unsuccessful and priscoline was used until shock supervened. Despite a blood transfusion and nor-epinephrine by infusion the patient expired on August 22, 1953. On the day of death the hemoglobin was 7.9 gm. per 100 ml., red count 2.94 millions per cu. mm., white count 24,900 per cu. mm. and platelet count 70,560 cu. mm. The clotting time decreased from four to one minute before death.

In summary, during the terminal phase of the patient's illness, multiple occlusions of arteries and veins were the prominent features. There was no source clinically apparent for multiple emboli. Thrombotic thrombocytopenic purpura was suggested by the low platelet counts, neurological findings and the anemia, but the occlusions of large vessels and the lack of purpura were felt to exclude this disease.

Pathologic Findings

Necropsy.—The body was that of a well developed, well nourished colored woman weighing 70.4 kg. and 146 cm. in length. There was no jaundice, cyanosis or petechiae of the skin. In the brain was found a ragged area of softening involving the left motor cortex and the subjacent white matter. The neck, breasts, pleural cavities and mediastinum were essentially unchanged. The left lung weighed 520 gm., the right lung weighed 370 gm. and there was hypostatic congestion in the posterior and inferior portions of both. There was an embolus, measuring 4 cm. in length and 3 mm. in diameter, partially occluding a small branch of the pulmonary artery to the right lower lobe. There was no pulmonary infarction.

The pericardium was normal. The heart weighed 255 gm. and there were scattered petechiae on the epicardial surface. Both right and left ventricles were slightly dilated. The myocardium was red brown and there were multiple small widely scattered foci of fibrosis. The tricuspid and pulmonary valves were normal. Attached to the cusps of the aortic and the leaflets of the mitral valve there were vegetations which individually measured 1 to 4 mm.; the total aggregate vegetation on a single cusp measured up to 1.0 to 1.5 cm. in diameter. These were on the ventricular surface of the aortic valve 0.5 cm. from the edge of the valve, and at the line of closure of the mitral valve leaflets. There was no stenosis or dilatation of the valve orifices. The coronary arteries were normal. The foramen ovale and ligamentum arteriosum were closed.

The peritoneum, pancreas, gall bladder and adrenals were normal. The spleen weighed 120 gm. and was dark red and firm; the trabeculae and follicles were normal. The liver weighed 1700 gm. and the contour and consistency were normal. In the gastrointestinal tract there were a few serosal and mucosal petechial hemorrhages. The left kidney weighed 120 gm., the surface was pale, the consistency was soft, and the capsule stripped with ease. On the surface were many petechial hemorrhages. The right kidney weighed 70 gm. and was similar to the left kidney. The bladder was normal.

The cervix and corpus of the uterus were atrophic, but otherwise unchanged. The right psoas muscle was hard and in the upper two thirds cut with difficulty. On section the muscle was divided by septa of white firm tissue.

The left leg was swollen, discolored and the skin was easily rubbed off. There was thrombosis of the femoral artery and vein and all vessels distal to these with gangrene extending from the lower third of the thigh and including all of the leg and foot. Similar changes were noted in the right arm and forearm, but these vessels were not examined. In the right iliac artery there was a firm pedunculated thrombus measuring 2 cm. in length and 0.7 cm. in diameter, partially occluding the lumen of this artery 4.0 cm. from its origin.

Histologic Examination.—There was pulmonary edema and hyperemia. A few of the pulmonary arterioles were involved by segmental hyalin thickening of the walls and there were a few small thrombi in the arterioles and capillaries. The mitral and aortic valves were slightly thickened and attached to the surfaces of these valves, with a sharp line of demarcation from the valves, there were vegetations which with hematoxylin and eosin stain were homogeneous, amorphous and eosinophilic. There were extremely few inflammatory cells and no bacteria in the vegetations. These vegetations were periodic acid Schiff positive; with Van Giesen stain they were yellow-green, no elastic fibrils being seen; with silver stains there were no elastic or silver positive fibrils (Fig. 1).

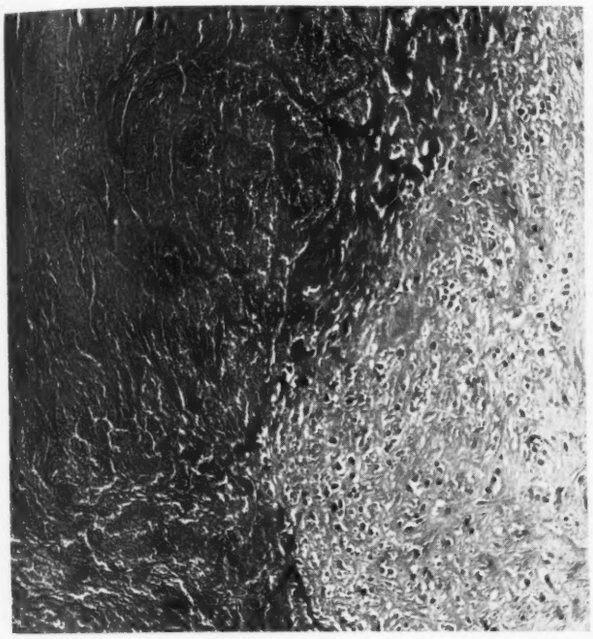

Fig. 1. Line of attachment of amorphus vegetation to a cusp of the aortic valve. Hematoxylin and eosin stain. x 80.

Throughout the myocardium there were small recent and old infarcts. There was segmental aneurysmal dilatation of some of the arterioles demonstrated by serial sectioning, and in some areas the walls of the arterioles were irregularly thickened by amorphous eosinophilic hyalin-like material with loss of the normal components of the arteriolar wall at that point (Figs. 2 and 3). This material was covered by plump endothelial cells. In some of the involved arterioles there were small thrombi, some of which were covered by endothelial cells. These thrombi were amorphous, eosinophilic, homogeneous masses, periodic acid-Schiff positive, yellow-green with Van Giesen's stain and were negative for fibren with positive phosphotungstic acid stains. There were no bacteria. There were similar capillary thrombi. The thrombi in the arterioles and capillaries of the lungs, kidneys, spleen and other organs had similar staining characteristics.

In the spleen there was marked passive hyperemia and changes in some of the arterioles. Hemosiderin containing macrophages were scattered throughout the spleen. In the liver there was moderate hyperemia characterized by dilatation of the central veins and the sinusoids surrounding these, with slight degeneration and regeneration of the hepatic cells in these areas. In the pancreas there were arteriolar lesions similar to those described in the heart. In the kidneys there were small healed infarcts and recent small infarcts; there were scattered, hyalinized glomeruli with thickening of the basement membrane of the glomeruli. Lesions of the arterioles and capillaries similar to those seen in the heart were present.

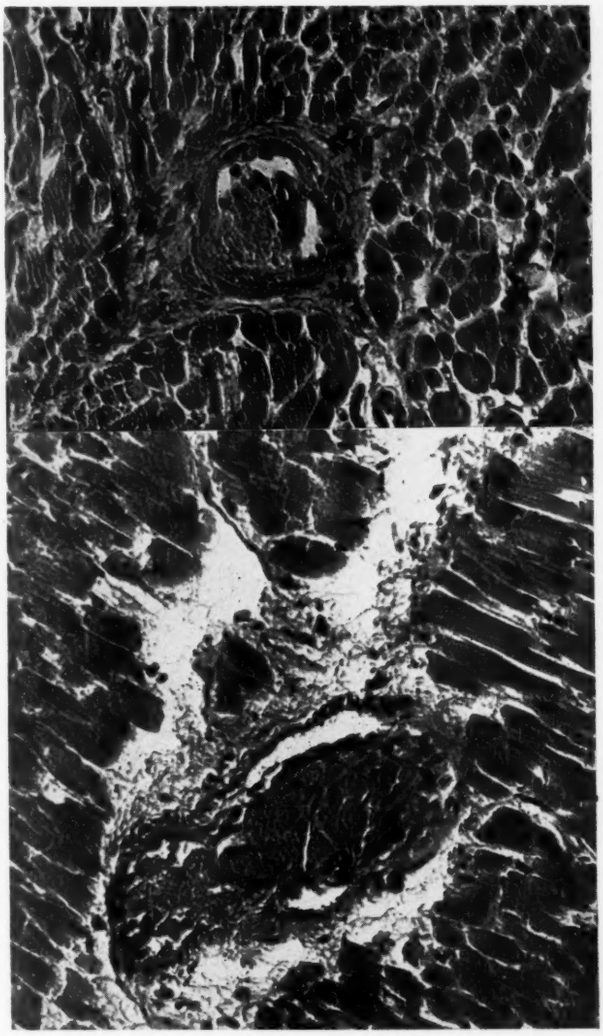

Fig. 2. *(above)* Platelet thrombus partially occulting arteriole of myocardium. Note focal destruction of arteriolar wall. Hematoxylin and eosin. stain. x 225

Fig 3. *(below)* Aneurysmal dilatation of an arteriole of the myocardium with an amorphus endothelial covered thrombus. Hematoxylin and eosin. stain. x 225.

In the right psoas muscle and right broad ligament there were nests of well differentiated squamous cell carcinoma which had invaded and destroyed the muscle

with resultant fibrous replacement and had also invaded lymphatics and veins. Many of the veins contained thrombi composed largely of fibrin. The uterus was atrophic. The cervix was atrophic and no demonstrable carcinoma present.

The adrenals were normal except for slight nodular hyperplasia of the cortex. There was thrombosis of the popliteal vein and artery of the left leg and gangrene of surrounding tissue. The thrombi were not Schiff positive and were composed mostly of fibrin, red blood cells and platelets. The bone marrow was moderately hyperplastic. In the brain there were lesions of the cerebellar arterioles which stained the same as those described above in the myocardium. There were multiple microinfarcts, especially prominent in the frontal lobes. A small arterial embolus was demonstrated in the left frontal lobe.

Discussion

The significant lesions in this case were arteriolar and capillary thromboses with microinfarcts, vegetations of the aortic and mitral valves and occlusions of the major vessels of the right arm and left leg. An incidental finding was carcinoma of the cervix, metastatic to the right psoas muscle and the right broad ligament.

The arteriolar and capillary lesions presented similar histologic and histochemical reactions to those reported by Meacham,[8] Gore[6] and others. These were aneurysmal dilatations of the involved vessels of the heart, segmental subendothelial amorphous thickenings of the walls, proliferation of endothelial cells and small amorphous thrombi, some covered by endothelial cells. These lesions were periodic acid-Schiff positive, phosphotungstic acid negative for fibrin, an amorphous yellow-green with Van Giesen's stain and acidophilic with H. and E. stains. The authors feel that the primary change is in the vessel wall with subsequent deposition of platelet thrombi.

The majority of the microinfarcts in the myocardium were moderately old with only a few recent lesions. However, in the kidneys most of the lesions were recent, with a relatively few older infarcts. We believe that this is additional evidence that the lesions occur in crops.

There was evidence of mild old rheumatic involvement of the mitral and aortic valves, characterized by small nodular hyalin thickenings, but there were no perivascular infiltrations or Aschoff bodies to indicate recent activity.

Because of the histologic structure and histochemical characteristics of the vegetations, the authors believe that these were composed primarily of platelets, with a small amount of fibrin also present.

In most of the cases in the literature in which these vegetations have been described complete staining characteristics have not been listed. They have been described as non-bacterial thrombotic endocarditis or as verrucous endocardosis. Since these are described as fibrinoid degeneration of the valve,[1,7] the vegetations in this case do not fit into this classification. Microscopically the lesions of verrucous endocardosis described by Allen and Sirota[1] are poorly demarcated from the valve, are composed by red blood cells, fibrin, and platelets, and loosened and fragmented collagen fibers. With silver stains, the lesions of verrucous endocardosis are shown to contain silver positive fibers. Therefore we conclude the vegetations in the case of thrombotic thrombocytopenic purpura are not identical with those of verrucous endocardosis.

The infarct of the left motor cortex was larger than those occurring in thrombotic thrombocytopenic purpura and represents an embolic phenomenon, probably from a dislodged portion of one of the vegetations. The mental changes and transient neurologic findings were no doubt due to the arteriolar lesions and the resultant microinfarcts, which were most pronounced in the frontal lobes. The euphoria was similar to that seen after prefrontal leukotomy.

Unfortunately blood studies were incomplete; however, some were so interesting that a discussion of these is justified.

On the day before death, the patient's clotting time was indefinite, i.e., more than twenty-four hours, and the prothrombin time by Quick's method was more than 80 seconds (less than 2 per cent "prothrombin"). Prothrombin determinations with Owren's P. and P. method were 16 per cent. To a portion of the patient's plasma was added large amounts of thrombin to induce clotting. No clot or fibrin threads were obtained, indicating a lack of fibrinogen in the patient's blood. As fibrinogen is added to the coagulation system in Owren's test but not in Quick's, this explains the discrepancy in the two results. The patient was inadvertently given 150 mg. of dicoumarol two days before, and this fact explains the reduction of prothrombin found by Owren's method.

The amount of antithrombin and fibrinolysin in the patient's plasma was not determined, but it is

not possible to explain the complete lack of clotting of the patient's plasma when thrombin was added by increased amounts of one of these substances. Since no clot was formed, we were unable to measure the amount of fibrinogen in the patient's plasma. According to a study by Schneider,[13] the amount of fibrinogen under such circumstances is less than 60 mg. per 100 ml. of plasma.

On the day the blood was found to be depleted of fibrinogen the patient had developed an occlusion of the right brachial artery; thirty hours previously she had had an occlusion of the left femoral artery. The reduction in the fibrinogen might be possibly explained as a result of "fibrin embolism" which has been reported in cases with placenta abruptio.[12] Fibrinogen is usually reproduced rapidly by the liver, and this was also evidently true in this case as the clotting time just before death was normal. At necropsy thrombi with many fibrin threads were found in the left femoral artery and vein. The question arises as to whether in thrombotic thrombocytopenic purpura there is depletion of fibrinogen and "fibrin clots." Fibrinogen levels in cases of thrombotic thrombocytopenic purpura have not been reported.

The finding of "fibrin embolism" in patients with placenta abruptio is thought to be caused by massive release of active thromboplastin from the placenta into the blood stream. In thrombotic thrombocytopenic purpura there apparently is disintegration and degeneration of platelets. It is possible, theoretically, that large amounts of platelet thromboplastin might be released under such circumstances. Platelet thromboplastin experimentally does not induce massive thrombosis or "fibrin embolism" even when injected in large amounts in the blood stream of animals.[11,13] However, the effect in humans might be different from that in animals.

Summary

An unusual case of thrombotic thrombocytopenic purpura is presented with endocardial vegetations, embolic phenomenon, lesions of the capillaries and arterioles and afibrinogenemia associated with thrombosis of major vessels. The authors believe that the latter may be secondary to the release of thromboplastinogen activating substance from the platelet thrombi.

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OLD MEN AMONG WORLD LEADERS

The world just doesn't seem to be able to get along without its old men.

Winston Churchill, for example, gave up his job as prime minister of Great Britain last April 5 because of his advanced age.

But today, at 81 reports are coming from London that his conservative party cannot get along without him.

There is chancellor Konrad Adenauer of the federal republic of West Germany. Adenauer will be 80 on January 5.

There is President Syngman Rhee of South Korea. Rhee admits to being 80 years old.

President Juho Paasikivi of Finland was 85 years old on November 27.

King Haakon VII of Norway should not be forgotten either, though he is not a leader in the political sense. Haakon was 83 last August 3.—*United Press.*

Physical Medicine and Rehabilitation: A Medical Care Specialty

I. Its Background, Scope and Philosophy

By Kathryn McMorrow, M.D., M.P.H.
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REHABILITATION has become a magic word in the past five years. There are rehabilitation centers, committees, physicians and lay people alike whose special avocation is rehabilitation. Within the medical profession itself, many orthopedists, some internists and others lay vociferous and often highly charged emotional claim to the term. Therefore it is necessary that the physiatrist, whose vocation is physical medicine and rehabilitation, define the term rehabilitation concretely and dispel the magic read into it by subjectively oriented enthusiasts.

Too many of the general profession are totally unaware that there are fundamental differences between the physician who is certified by the American Board of Physical Medicine and Rehabilitation and other physicians who use the term loosely in describing themselves. There are also fundamental differences in the practice of medicine by the physiatrist and others rendering patient care.

Because the physiatrist has failed to point out these differences from the beginning to the profession, he has allowed a very serious ethical problem and a definite economic danger to arise within the general profession. Both have grown out of the irresponsible use of rehabilitation as a magic bagatelle.

Rehabilitation is that mechanism in the therapeutic process by which the therapeutic process may be hastened and the therapeutic goal extended through the objective use of paramedical persons. There is no magic in catalyzing the progress of a patient toward independence. It is hard and often laborious work over a period of months and years to restore a patient to the fullest physical, mental, emotional, social and vocational independence of which he is capable. Rehabilitation is not the restoration of the patient to his final capacity. It is the mechanism whereby such restoration is accomplished.

The physiatrist differs from other physicians only in that he objectively recognizes the fact that rehabilitation is a mechanism in the therapeutic process, and that the mechanism can be catalyzed by the objective use of paramedical persons. The basic physiatric technique which he learns in three years of residency and fellowship is the ability to write precise, accurate, detailed individual prescriptions for his patient to be filled by the paramedical person. No other practitioner of medicine is so trained. This includes the psychiatrist who was the first to recognize the mechanism in healing called rehabilitation, but who still, in the majority, uses the occupational therapist subjectively on a referral basis to render medical care to his patient. It also includes the orthopedist who has been most vehement in his demand that the physiatrist relinquish the term rehabilitation. The basis of his demand lies in his thorough familiarity with the physical therapist. He, however, is not trained in physical therapy techniques, and he certainly has not been taught the objective prescriptive use of the occupational therapist, speech and hearing therapist, the clinical psychologist, social case worker and vocational counsellor. In fact, he who most angrily denounces the physiatrist is least likely ever to have read the requirements which the American Board of Physical Medicine and Rehabilitation expects the physiatrist to fulfill.

This does not mean, and this must be stressed, that the physiatrist is egregious. He never has nor could claim that no other physician can prescribe accurately for anyone or several of the paramedical persons involved in the mechanism of rehabilitation. He must state his certification in his specialty indicates that he can prescribe accurately for a patient in need of any or all of the services of these paramedical persons. It is his trademark, his vocation, his specialty.

This brings into focus the serious ethical problem which faces the general profession and the economic threat to the profession. Through ignorance and by default, the physician has (and will for some time to come) referred a patient for medical care services to a person not trained or licensed to practice medicine. There are two chief reasons which account for this breach in ethics: (1) The physician (by reason of medical school training and community practice) discounts the value of, e.g., "physiotherapy." (2) He is overwhelmed (by reason of medical school training

and community practice) by the technical knowledge of, e.g., "clinical psychologist." Unfortunately, both these groups and others in a similar category are (1) hurt because the physician discounts their special training and (2) disdainful because the physician displays such obvious ignorance. It is most human to arrive at the conclusion that they in isolation are much more important than the physician in treating the patient. It is then very easy to persuade the patient toward their subjective belief. We then have the unethical phenomenon of a person practicing medicine without a license, with the physician contributing to this unethical practice.

Simultaneously there arises a most vicious practice which threatens the entire American people here and now. It is both a matter of ethics and of economics. Again it is most human to ignore the former and endorse the latter when an individual or a group is threatened. It is imperative that the general profession adhere to the former if it is to survive the economic threat of third party payment.

Each and every physician in private practice today has had experience with fee for service paid him from the three sources of funds for medical care today: tax funds, eleemosynary funds and assurance funds. Few have escaped an occasional twinge of anxiety and some of us have become deeply concerned with the increasingly widespread attitude in which the administrators of these funds tend to become protectors of a business rather than a liaison between directors and trustees and the medical profession.

The practice of medicine includes both a professional (ethical) area and a business (economic) area. The professional part of medical practice is basic. Illness makes a patient dependent on his physician for help back to health. Only a properly trained and licensed person can give this help legally and ethically. The business part of medicine is divided in two: the fee for service which is the source of livelihood for the physician and his family, and the cost of the materials and facilities which he must use in managing his patient. It is necessary that the physician have control of both.

However, many a general practitioner today is acutely aware that he does not have control of necessary facilities particularly when he needs a bed for his patient. It is not at all uncommon in metropolitan areas for him to be entirely unable to secure a bed in hospitals where special rules allow him only to refer to a specialist. But bad feeling is created in the mind of the specialist when the general practitioner refuses to make a house call half-way across the city for the specialist. There is danger in condoning this situation wherever a third party interferes with the professional practice of medicine. Too often the specialist forgets that his livelihood depends on referrals from the general practitioner and assumes the irrational role of liaison officer between the profession and the hospital administrator, rather than using his influence in bringing about the more rational situation in which the hospital administrator acts as a liaison between the civic-minded members of the board of trustees and the equally civic-minded members of the general profession.

It is small wonder today that patients are confused, when we day after day continue to foster situations which compound the confusion. It is vital that the profession take back its prerogatives lost in the growth of organizations dependent on third party payment.

In conclusion, this appears to be a far cry from physical medicine and rehabilitation as a medical specialty. However, the physiatrists form a hard core of physicians who are in daily contact with patients, other physicians, paramedical people, executive directors and administrators of tax, eleemosynary and assurance funds, and with the civic-minded businessmen who control expenditures. We know it is our duty to point out to the general profession that its business is with the trustees of the hospital, insurance company and social agencies and not with the executive directors of these organizations. Let the executive director return to his traditional role of executing policy rather than forming policy. Formation of policy is the business of the board, and policies will be rational once the profession resumes its responsibility for keeping the various civic-minded individuals informed regarding the need of facilities for patient care. These facilities all are eventually paid for by the people and all physicians are licensed to practice by the people.

The physician-organization problem can be resolved in the best interest of the public by a logical approach with fact and reason. All members of our profession can render patient care in,

(Continued on Page 1432)

Treatment of Rheumatoid Arthritis and Osteoarthritis with Succinate-Salicylate

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THE primary purpose of this study was to evaluate the therapeutic results of succinate-salicylate therapy in cases of early active rheumatoid arthritis and osteoarthritis over a protracted period.

Thirty cases in each of the two groups were treated and observed over a two-year span. All patients in both groups were given a trial of massive acetylsalicylic acid therapy (80 grains per diem) for three months, resulting in drug toxicity in a major or minor degree without accomplishing objective improvement. A few patients had undergone ACTH-cortisone therapy previously without permanent objective results.

In the treatment of various types of arthritic conditions it has long been known that salicylates, administered in massive dosage, frequently cause undesirable side effects. Gastrointestinal disturbances, tinnitus, and rashes are commonly observed. While not of a serious nature, these side effects have proved a serious deterrent to the wider use of salicylates in massive and adequate dosage.

Recent findings of investigators in this country and abroad offer conclusive evidence that the action of salicylates in arthritic conditions is similar to that of ACTH-cortisone.[1,12,18]

Hailman[12] has summarized and tabulated the extensive medical literature bearing on the biologic similarities between ACTH-cortisone and salicylates.

Bach, in England, states that "similar chemical and biochemical changes occur with the administration of salicylates, ACTH, and cortisone. Rheumatic activity is suppressed. Salicylates exert their pharmacological activity by engendering adrenocortical excess."[1]

There is also evidence that salicylates and ACTH-cortisone act similarly to suppress experimental arthritis,[18] suppress skin sensitivity reactions,[8,24] suppress inflammation,[9] suppress allergic disorders and serum vascular disease,[7,10,20,25,27] protect against anaphylactic shock,[6,19] depress gamma globulin and antibody formation,[15,16] increase 17-Ketosteroid excretion,[2,30] deplete adrenal cholesterol and ascorbic acid,[3,14,22,29] cause fall in blood eosinophiles,[17,23] increase uric acid excretion,[28] cause negative nitrogen balance,[21] inhibit spreading effect of hyaluronidase.[11]

The similarities of the salicylates and the cortical hormones are especially noteworthy with regard to their therapeutic action in arthritic and rheumatic disorders. In selecting a program of treatment for the arthritic patient, however, it must be borne in mind that, as Hench points out,[13] cortisone is not justified in patients with active tuberculosis, pyschoses or severe psychoneuroses, cardiovascular or renal disease, diabetes mellitus, osteoporosis, peptic ulcer, or convulsive disorders. Furthermore, as concluded by Brown et al,[4] cortisone is difficult to justify in the treatment of osteoarthritis.

On the premise that salicylate therapy is preferable to cortical hormone therapy in a long-term program, but mindful that ordinary salicylates, administered in adequate dosage, are apt to cause a high frequency of toxicity, this study undertook to evaluate a combination of succinate-salicylate* which a group of investigators in 1954 had found highly efficacious and considerably less toxic than ordinary salicylates.[5]

Rheumatoid Cases

All thirty cases of rheumatoid arthritis were clear-cut and had at least a two-year follow-up. The Therapeutic Criteria in Rheumatoid Arthritis established by the American Rheumatism Association in 1949 was used. Questionable cases were omitted. No cases of rheumatic fever, rheumatoid-like disorders, and gout were included.

The cases were predominately females; 75 to 80 per cent were between the ages of forty-one and fifty-one years of age. All cases were acute, polyarticular with fusiform joint swelling, pain, stiffness, and warmth to the affected joint. Only four patients had muscular atrophy adjacent to the affected area. None had subcutaneous nodules.

The majority of patients appeared acutely ill (93 per cent) with general malaise, fever, and tachycardia, but to a minor degree. Onset of symptoms occurred within one week and subsided after two weeks of therapy. Temperatures varied from 99.0° to 101°, the majority having temperatures of

*Ber-ex tablets furnished by Pan Pharmacals, Inc., New York, N. Y.

TABLE I. CLASSIFICATIONS OF RHEUMATOID PROGRESSION IN 30 CASES IN STUDY[26]

Stage	Roentgenologic Signs	Muscle Atrophy	Extra-Articular Lesions (Nodules Teno-Vaginitis)	Joint Deformity	Ankylosis
I	Osteoporosis (no destructive changes) 25 cases (83.3%)	0 0	0 0	0 0	0 0
II	Osteoporosis (slight cartilage or subchondral bone destruction were present) 5 cases (16.7%)	Adjacent 4 cases (13.2%)	May be present 0	0 0	0 0
III	Osteoporosis (cartilage destruction, bone destruction) No cases	Extensive	May be present	Subluxation, ulnar deviation, and/or hyperextension	0
IV	Same as III with bony ankylosis No cases	Extensive	May be present	Same as III	Fibrous or bony ankylosis

TABLE II. CLASSIFICATION OF FUNCTIONAL CAPACITY IN 30 CASES IN STUDY[26]

Class	Before Therapy	After Therapy
I	Complete Ability to carry on all usual duties without handicaps No cases	25 cases (83.3%)
II	Adequate for Normal Activities Despite handicap or discomfort or limited motion at one or more joints 25 cases (83.3%)	5 cases (16.7%)
III	Limited Only to little or none of duties of usual occupation or self care 5 cases (16.7%)	None
IV	Incapacitated, Largly or Wholly Bedridden or confined to wheelchair; little or no self care No cases	No cases

100.2°. Their joints were painful, stiff, swollen, and warm to palpation. Limitation of motion varied from 10 to 30 per cent by goniometer and tape measure recordings.

All cases had elevated erythrocyte sedimentation rates (Winthrop) from twenty-four to fifty which fell to normal in thirty days with therapy.

Routine complete blood counts were done in all cases. All had leukocytosis varying from 9,500 to 12,500. The majority had a white-cell count of 10,400. This returned to normal after two weeks of treatment with succinate-salicylate and remained so for two years. Red blood cells varied from 2,560,000 to 3,950,000 at the onset. Correction with iron therapy resulted in three months.

Routine urines checked initially and at monthly intervals were always negative. Prothrombin rates were normal at the onset and remained so during the two-year period of therapy. They were also checked at monthly intervals.

Routine blood sugars initially were slightly elevated in only two cases and were normal after one month of therapy. Basal metabolic rates, done where indicated, revealed no abnormalities.

Roentgenograms were taken in all cases of the involved joints and only five (about 17 per cent) showed changes. There was only slight haziness and narrowing of the interarticular spaces in all of these patients. They were unchanged over two years, as shown by roentgenograms.

Distribution of the rheumatoid arthritic joints were as follows:

Fingers and knuckles	86%
Knees	7%
Shoulders	7%

In all cases more than one joint was involved.

Joint mobility was increased in all patients according to goniometric and tape measure recordings. Using 100 per cent as normal range of motion, the following table was compiled.

JOINT MOBILITY IMPAIRMENT

Per cent of Impairment	Impairment at Onset	Impairment after 14-days of Therapy
10%	32%	0%
20%	60%	0%
30%	8%	5%

Thus two weeks of therapy did a great deal to improve limited motion of the involved joints.

Dosage

Succinate-salicylate (Ber-ex) contains per tablet, calcium succinate 2.8 grains, acetylsalicylic acid 3.7 grains. Succinate-salicylate tablets (Ber-ex) were administered to all cases of rheumatoid arthritis in the dosage of twenty-four tablets daily (6 q.i.d.) before meals for twenty-one days; then sixteen tablets (4 q.i.d.) for thirty days, or until a remission in the rheumatoid joints occurred; then twelve (3 q.i.d.) for thirty days, and a maintenance prophylaxis dose of four tablets daily. Mild relapses occurred in only two cases, and then the tablets were increased to twenty-four daily for only one week, following which dosage was accordingly stepped down.

Toxic symptoms were minimal.

TOXIC SYMPTOMS

Nausea	Vertigo	Emesis	Rash
21%	7%	3.5%	0%

TABLE III. RESPONSE OF RHEUMATOID ACTIVITY TO THERAPY IN 30 CASES AFTER SUCCINATE-SALICYLATE THERAPY FOR TWO YEARS[26]

Grade	Systemic Signs	Signs of Joint Inflammation	Signs of Extra Articular Activity	Remaining Impairment of Joint Mobility	Articular Deformity	Erythrocyte Sedimentation Rate	Roentgenologic Signs
I. Complete Remission 28 cases	28 cases (93%) prior to therapy. No cases after 2 weeks of therapy for 2 years.	30 cases prior to therapy. No cases after two years of therapy.	No cases	Due only to irreversible changes. 4 cases (13%) after therapy for 2 weeks.	Due only to irreversible changes. No cases	30 cases had an elevated sed. rate which fell to normal after 2 weeks and remained normal.	All 30 cases. No progression.
II. Major Improvement	Elevated erythrocyte sedimentation rate and/or vaso-motor imbalance permissible.	Only minimal residual joint swelling (no new sites)	Minimum (no new sites)	Only consistent with minimal residual activity	Due only to irreversible changes	May be elevated	No progression
2 cases	2 cases (7%)	No cases	No cases	Mobility reduced— 2 cases (7%)		No cases	No cases
III. Minor Improvement	Decreased	Only partially resolved (no new sites)	Decreased (no new sites)	In relation to residual inflammation	May be present	May be elevated	No progression
	No cases	No cases	No cases	No cases	No cases	No cases	No cases
IV. No Improvement	Undiminished	Same or worse	Same or new sites or exacerbation*	Same, better or worse	Present or not	Any rate	Changes indicative of progression
	No cases	No cases	No cases	No cases	No cases	No cases	No cases

Where nausea occurred one aluminum hydroxide tablet with each dose of succinate-salicylate was given, with a snack of crackers at bedtime. Where emesis occurred this was eliminated when the dosage was changed to after meals. Vertigo was controlled with mild laxatives and a glass of hot water on arising. As a result toxicity was low and the dosage of drug did not have to be altered in any case.

To avoid any confusion, cases of co-existing stages in the same patient were included in the Tables I, II and III. The joint with the most involvement was used as the basis of classification as recommended by the "Therapeutic Criteria for Response of Rheumatoid Arthritis," by the American Rheumatism Association in 1949.[26]

Thus of the thirty cases of acute active rheumatoid arthritis, twenty-five cases fell in Stage I, and five cases in Stage II; twenty-five cases in Class II prior to therapy advanced to twenty-five cases in Class I after therapy; five cases in Class III prior to therapy advanced to five cases in Class II after therapy.

In response to therapy, twenty-eight of the thirty cases revealed complete remissions; two cases had relapses, each lasting for a period of one week after one year of therapy. In both relapsed cases the joint mobility was improved markedly. There were no signs of joint inflammation, extra-articular activity or deformity, and the erythrocytic sedimentation rates were normal. No changes were shown by roentgenograms.

Successful therapy for two years maintained these thirty cases of rheumatoid arthritis with only two relapses. Drug toxicity was minimal and symptomatic and objective improvement was dramatic.

Osteoarthritis Cases

All of the thirty cases of early osteoarthritis were followed for at least two years. Cases in this study were limited to those showing joint involvement of the extremities. Patients showing roentgenological questionable or definite spinal involvement were eliminated for clarity of data presentation.

Females predominated this series also: 75 to 90 per cent between the ages of fifty-one and seventy years. In all patients, the onset was insidious with symptoms and signs of arthritis persisting for at least a three-year period. All were well nourished, but 7 per cent were obese. Symptoms consisted of joint stiffness in both large and small joints, pain, swelling, and limitation of motion. These osteoarthritic patients also complained of general fatigue. All were afebrile. Acute symptoms subsided after two weeks of therapy. Limitation of motion varied from 10 to 30 per cent by goniometer and tape measure readings.

All cases had erythrocyte sedimentation rates (Winthrop) which were normal with the exception of two cases which showed a 10 per cent elevation that fell to normal in twenty-nine days. All cases checked bi-monthly remained normal.

Routine complete blood counts done in all cases

were normal as well as complete urine examinations at monthly intervals.

Prothrombin rates were normal at onset and remained so during the entire two years of follow-ups at monthly intervals.

Blood sugars were elevated slightly (140 mg. per cent) in three cases but returned to normal after one month of therapy; basal metabolic rates (Jones) were done where indicated but were normal except for one obese patient who had a —15 reading and was treated symptomatically, resulting in a normal reading in six months.

Roentgenograms taken in all cases of the involved joints revealed some lipping and spur formation in six cases. The rest were normal.

DISTRIBUTION OF DEGENERATIVE JOINTS

Knees	52%
Shoulders	30%
Fingers	10%
Hips	8%

The knees were the joints predominantly involved. In most cases more than one joint was involved and mobility was decreased. Using 100 per cent as normal range of motion the following table was compiled. All patients were measured by goniometric and tape measure recordings.

JOINT MOBILITY IMPAIRMENT

Per cent of Impairment	Impairment at Onset	Impairment after 14 Days of Therapy
10%	30%	0 %
20%	60%	14 %
30%	10%	3½%

Thus, fourteen days of treatment improved joint mobility considerably and this improvement remained for two years of follow-up.

Dosage

The same dosage schedule was used in all cases as in those of rheumatoid arthritis.

TOXIC SYMPTOMS

Nausea	Vertigo	Emesis	Rash
14%	3½%	0%	0%

Toxic symptoms were rare in this group also. Where nausea occurred same procedure was followed as with the rheumatoid cases, and toxicity was eliminated.

Symptoms of pain, stiffness, and swelling were based on degree from one to four plus.

OSTEOARTHRITIS (30 CASES)

	Initial Severity	Final Severity	Days until Maximum Change
Pain 30 cases	3+	0	10 days
Stiffness 30 cases	4+	24 cases—0 6 cases—1+	16 days
Swelling 30 cases	1+	0	6 days

Relief of symptoms and restoration of mobility were dramatic on maintenance dosages for the two year period with complete functional capacity, except for the six cases showing x-ray changes where damage was irreversible as proven by follow-up x-rays at the end of the two year period. There were no cases of muscle atrophy or severe joint deformity in the series. Twenty-four cases could be classified as Class II or adequate for normal activities despite the handicap of discomfort and limited motion of their joints, prior to therapy. They became Class I after two weeks of therapy and remained thereafter in this class. Six cases in Class III advanced to Class II after two weeks of therapy and remained in that classification for two years.

CLASSIFICATION OF FUNCTIONAL CAPACITY IN 30 CASES OF OSTEOARTHRITIS[26]

Class		Before Therapy	After Therapy
I	Complete Ability to carry on all usual duties without handicaps	No cases	24 cases (79%)
II	Adequate for normal activities Despite handicap of discomfort or limited motion at one or more joints	24 cases (79%)	6 cases (21%)
III	Limited Only to little or none of duties of usual occupation or self care	6 cases (21%)	None
IV	Incapacitated, largely or wholly Bedridden or confined to wheelchair; little or no self care	No cases	No cases

Functional capacity was greatly increased. Maintenance dosage controlled improvement with no flare-up of joints. Drug toxicity was minimal and both symptomatic and objective improvement resulted in this series of cases.

Comment

Results of this study of sixty cases of early arthritis (thirty rheumatoid, thirty osteoarthritis) were excellent over a two-year follow-up period. Patients responded well to therapy with immediate relief of symptoms and excellent objective improvement of their joints. Toxicity was minimal. Salicylate toxicity was obviated. The administration of succinate salicylate was uncomplicated.

It must be remembered, however, that all cases studied were in these early stages of these arthritic disorders. All had failed to tolerate large doses of acetyl-salicylate and, for a three-month period on this therapy, had failed to show objective improvement.

The combination of calcium succinate and acetylsalicylic acid (Ber-ex) proved far superior to acetylsalicylic acid alone not only as regards to toxicity but therapeutic results as well.

With this combination swelling was reduced as rapidly as impaired joint mobility and pain. Follow-up therapy could be maintained on a small dosage effectively. There were only two cases of relapses in the rheumatoid group in two years and response to resumed massive therapy was more rapid than originally.

Summary and Conclusions

1. Succinate-salicylate proved to be an excellent therapeutic agent in correcting the signs and symptoms in both osteoarthritis and rheumatoid arthritis in two weeks.
2. Succinate-salicylate therapy was notable for low toxic manifestations.
3. Prevention of probable relapses appears to have been made possible by the use of succinate-salicylate.
4. Fewer and milder side effects than with acetylsalicylic acid were obtained.
5. Sedimentation rates in rheumatoid cases rapidly became normal and remained so.
6. Prothrombin rates did not change.
7. Results were lasting and apparently affected the disease process itself over this two year follow-up.
8. Succinate-salicylate did not require excessive supervision required of other therapy as ACTH, cortisone, gold, et cetera, physical therapy, rehabilitation, psychotherapy and orthopedic corrections.
9. Succinate-salicylate proved to be a drug of choice in early arthritis where salicylates are indicated.

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PHYSICAL MEDICINE AND REHABILITATION:

A Medical Care Specialty

(Continued from Page 1427)

and work with, any organization providing medical care facilities. The physician must be allowed to control his practice directly and through the code of ethics of the American Medical Association and his county society. If he does not exercise his privilege as granted through his license to practice, eventually his profession, including his livelihood, will attract only second rate minds and persons, with lowered standards of care for the people who consult with him for relief.

Infectious Hepatitis in Washtenaw County, Michigan

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AN unprecedented increase in the number of infectious hepatitis cases reported to the Washtenaw County Health Department during the spring and early summer of 1953 indicated the need for an epidemiologic investigation to search for relevant and remedial factors. This report presents the procedures followed in the investigation and pertinent findings.

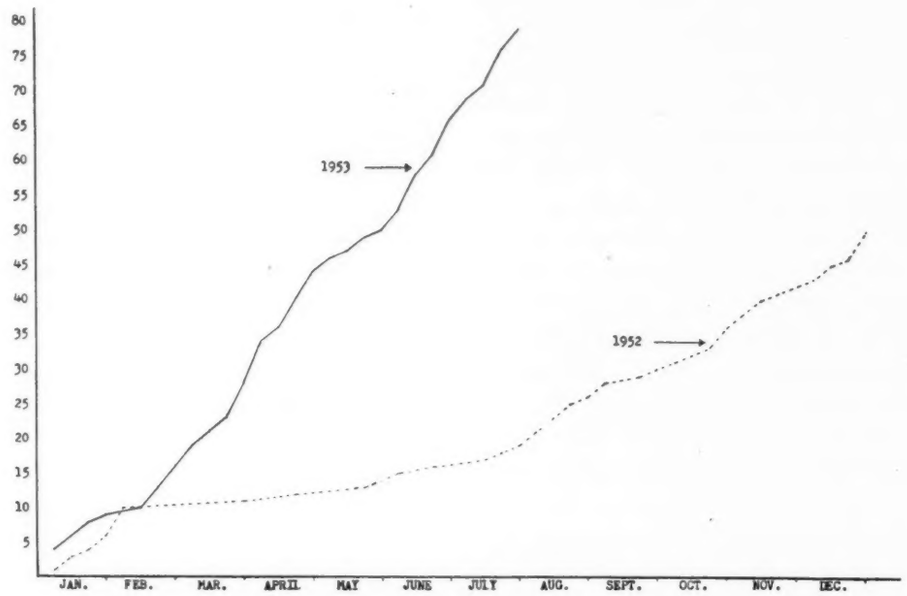

Fig. 1. Cumulative cases of infectious hepatitis in Washtenaw County.

Procedures

The first was that of determining, as accurately as possible, the extent of infectious hepatitis in Washtenaw County and two measures were chosen to obtain the desired information. First, by prior arrangement, lists were secured of all infectious hepatitis patients hospitalized at St. Joseph's Mercy Hospital, University Hospital, and Beyer Memorial Hospital during 1952 and the first three months of 1953. These three general hospitals comprise almost all of the hospital facilities of Washtenaw County. The hospital records were reviewed for age, sex, race, address, occupation and any pertinent facts in the recorded history related to the etiology and epidemiology of the patient's infection. Secondly, a list of all reported cases was compiled up to August 1, 1953. To enlist the co-operation of the physicians of Washtenaw County in this project, a letter was sent to each doctor explaining the study and its purpose.

These approaches disclosed 129 diagnosed cases of infectious hepatitis in Washtenaw County from January 1, 1952, to August 1, 1953. Of the 129 cases, seventy-nine of them occurred from January 1, 1953, to August 1, 1953. The corresponding period of 1952 revealed only nineteen cases. This represents an increase of 316 per cent in 1953, over the same chronological period of 1952. A comparison of rate of transmission for 1952 and 1953 is shown graphically in Figure 1. The curve showing 1952 cases definitely leveled off from February to June and indicated increasing incidence again in the latter part of June. The 1953 curve plotted out almost a straight line indicating a constant rate of transmission. The etiologic agent appears to have run the gamut without any notable interference. Havens and Paul[1] state that in certain parts of the world the disease follows a distinct seasonal trend, a sudden rise occurring in the autumn, reaching epidemic proportions in the winter and declining in the spring. While the 1952 curve presents this general pattern, the 1953 curve differs significantly.

In order to establish their distribution the recorded cases were plotted on county maps ac-

TABLE I. CASES PER 100,000 POPULATION
1952-1953

Community	Population	No. of Cases (first 7 mos.)		No. of Cases per 100,000 pop.	
		1952	1953	Jan. 1 to Aug. 1, 1952	Jan. 1 to Aug. 1, 1953
Rural area (Washt. Co.)	45,981	12	25	26.10	54.37
Ann Arbor	48,251	4	19	8.29	39.38
Ypsilanti	18,302	2	4	10.93	21.86
Willow Run Village	11,365	1	12	8.80	105.59
Chelsea	2,580	0	2	0	77.52
Dexter	1,307	0	6	0	459.07
East Ann Arbor	1,826	0	0	0	0
Milan	2,073	0	6	0	289.44
Saline	1,533	0	5	0	326.16
Manchester	1,388	0	0	0	0
Washtenaw County (Total)	134,606	19	79	14.12	58.69

cording to location. These maps did not demonstrate a well-defined pattern but rather a shot gun distribution. The population of Washtenaw County and the individual cities within the county in relation to the number of cases per 100,000 population for 1952-1953 (first seven months) is given in Table I.

Of the total cases, 37 per cent of those during 1952-53 occurred among rural inhabitants, who comprise 34 per cent of the total Washtenaw County population, while 63 per cent of the cases appeared in the cities and incorporated villages which make up 66 per cent of the county census. Other calculations revealed that 63 per cent of the total number of cases of infectious hepatitis for the first seven months of 1952 occurred in the rural areas. Infectious hepatitis among rural inhabitants accounted for only 32 per cent of the cases reported during the corresponding period in 1953.

The next phase of this study involved interviewing those persons who were reported as cases. Thus epidemiologic data were obtained by talking with patients and their families and observing their home environment. Since more accurate information would be procured by interviewing the more recent cases in preference to those with an earlier onset and because of time limitations, the interviews were limited to the 1953 cases. The group of patients interviewed consisted of twenty males and twenty-one females. No criteria of selection were used for patients to be interviewed and this group of forty-one represents those which could be contacted within the time limitations.

After determining what information was desired a series of questions was formulated. The same questions were asked of each patient and the answers recorded on master charts to facilitate study and analysis. The resulting information consisted of the following: Name and address of the patient, age, sex, race, date of onset, attending physician; contacts with known infected persons; condition of other members of the household; school or place of employment; source of water, milk, and food; type of sewage disposal; dates of transfusions, venapunctures, and inoculations; other possible exposures to infection, and date of administration of gamma globulin to the patient, if any.

Summary of Data

The subsequent sections are devoted to a summary of the data based on detailed studies of forty-one patients.

1. The localities in which the interviewed patients resided is shown in Table II.

TABLE II

Community	*No. of Patients*
Ann Arbor	16
Dexter	4
Milan	4
Saline	5
Ypsilanti	1
Rural or small residential areas of Washtenaw County	11

2. The ages of the patients ranged from three to fifty-eight years. Table III shows the number of cases according to age groups.

TABLE III

Age in Years	*No. of Patients*	*Per Cent of Interviewed Patients*
3-10	12	29.3
11-20	15	36.6
21-30	10	24.4
31-40	3	7.3
Over 40	1	2.4

Havens and Paul[1] state that most epidemic cases fall in the age group of five to seventeen years but that it is also common in young adults. The findings are in agreement.

3. On the basis of the cases reported, the etiological agent manifested no predilection for one sex over the other.

4. The matter of racial susceptibility or resistance to infectious hepatitis was not given special consideration. However, a review of the complete record for 1952-53 has shown that there have been 127 cases among the white population as compared to two in the colored. Population ratios of Washtenaw County are about thirteen white to one colored.

5. Table IV shows by month, the total cases and the cases included in this study.

TABLE IV

Onset (1953)	No. of Cases Studied	Total Cases Reported
January	2	9
February	1	7
March	7	12
April	7	16
May	3	6
June	13	15
July	8	14

6. While discussing possible contacts with infected persons, nineteen patients gave a history of association with one or more persons who had had infectious hepatitis within a month prior to their own illness. Table V shows the number of patients by type of contact. A definite contact is considered one who had had jaundice and was closely associated with the patient, whereas possible contact is defined here as meaning that the activities of the patient had placed him in an evironment where previous cases of hepatitis had occurred.

TABLE V

Contacts with Infected Persons	No. of Patients	Percentage
Definite intra-family contact	11	26.8
Definite extra-family contact	8	19.5
Possible extra-family contact (school)	6	14.6
No known contacts	16	39.0

Six patients are listed as having had possible extra-family contact. They were pupils at a particular school in which there had been cases of infectious jaundice. However, specific contacts of this group of six could not be verified.

7. The query pertaining to school or place of employment revealed that eleven of the interviewed patients attended the same parochial school in Ann Arbor. This situation is discussed in a subsequent section dealing with special group studies. The other thirty responses to this question appear insignificant since there were as many different employers and schools mentioned as there were patients.

8. Table VI gives the different water sources and the number of patients using each source.

TABLE VI

Water Source	No. of Patients	Percentage
Private well water	9	22
Community well water	3	7
Municipal water supply	29	71

Water samples from several of the wells were taken and tested for the presence of coliform bacteria. These tests established that the samples were free of colon bacilli. There was no recourse to practical laboratory procedures to determine the presence or absence of viruses. Persons receiving water from community wells had the water piped directly into their homes.

9. All of the patients, with the exception of one, purchased pasteurized dairy milk. The one patient used raw milk from the family cows. The names of the dairies patronized by patients accounted for ten different dairies supplying these people with milk and milk products. This finding indicated that there was little probability that any one or two sources of contaminated milk or other related products were the responsible entities in transmission, of the infection in this study. Food for the patients came from a variety of stores. Large chain stores were mentioned most frequently although a number of smaller, independent stores were patronized. There was no exploration of particular foods consumed with the exception of dairy products as stated.

10. That the feces of infectious hepatitis patients contain the virus has been confirmed. "The virus is readily recovered from the blood and feces of patients in the acute, preicteric, or early icteric phases of the disease, and may be transmitted to human volunteers by feeding or by parenteral inoculation of infectious materials."[1] Table VII shows the number of patients and percentage of the forty-one persons interviewed by type of sewage disposal.

TABLE VII

Type of Sewage Disposal	No. of Patients	Percentage
Community	28	68.3
Septic Tank	8	19.5
Privy	5	12.2

Several of the families informed us that they had had some difficulty with proper drainage of sewage by their septic tank systems. The relation of inadequate functioning systems to the incidence of this series of cases of hepatitis has not been determined.

11. A distinction must be made between infectious hepatitis and homologous serum hepatitis since both have very similar symptoms and clinical findings. The incubation period is one point of difference. Whereas the incubation period for infectious hepatitis is 10 to 40 days, it varies from two to six months for homologous serum jaundice. Therefore, the dates of any transfusions, venapunctures, or inoculations were important in considering the possibility of serum jaundice. Table VIII consists of each case who had received inoculations, frequency of inoculations for each patient, and the approximate time lapse from the inoculation to the onset of the hepatitis.

TABLE VIII

Case	Frequency of Inoculations	Time Lapse from Inoculation to Onset
1	1	1 month
2	1	1½ months
3	3	3½, 2½, 1½ mos.
4	1	15 days
5	2	2½, 2 months
6	1	1½ years
7	2	2½ months
8	1	3 months
9	2	3.2 months
10	1	1½ months
11	1	5 days
12	1	5 months

Twenty-nine of the forty-one patients had received no inoculations at all. In only six of the inoculated patients was there a sufficient time lapse from inoculation to onset to suggest the possibility of homologous serum jaundice. Since most cases reported no transfusions, venapunctures, and inoculations the conclusion was reached that the bulk of these cases were a part of an epidemic of infectious hepatitis.

12. The information obtained concerning other possible exposures to infection was extremely varied and also difficult to interpret in terms of importance as potential sources of infection. Eleven of the forty-one patients attended the school previously referred to and four of the eleven also lived in rural areas. Four of them had been on trips outside of Michigan visiting and stopping in rural areas in route and each of these patients became ill within a month following their trip. Five lived in rural areas where they had well water and septic tanks. Five had visited rural areas in Washtenaw County within a month prior to their illness.

13. No attempt was made to evaluate the effectiveness of gamma globulin by this study because none of the persons interviewed had received the gamma globulin before his illness.

Specific Group Studies

During the course of the survey there appeared three specific groups of cases which warranted special attention. The first situation involved a school. The first case appeared in the sixth grade on April 26, 1953, and a second case followed two days later. Both boys lived in rural areas, one southwest and the other north of Ann Arbor. The incidence gradually but steadily increased until a total of thirteen cases had been recorded by July 24, 1953. For purpose of comparison, the other fifteen Ann Arbor schools were surveyed for 1953 infectious hepatitis cases; the results are given in Table IX.

TABLE IX

Elementary School	Enrollment	Number of Cases
A	248	0
B	216	0
C	694	0
D	128	1
E	353	0
F	258	0
G	411	0
H	757	1
I	638	0
J	516	0
K	828	0
L	156	0
M	150	0
High School		
A	1151	0
B	255	1
Combined Elementary and High School		
A	574	13

A check of the distribution within the school revealed that the majority of the cases occurred in the lower grades, as is evident in Table X.

TABLE X

Grade	Number of Cases
2nd	2
4th	2
6th	5
8th	1
9th	1
10th	1
12th	1

The rate of progress through the school is illustrated graphically in Figure 2. The graph shows both accumulative cases and the number of cases per week. After the interviews it was evident that close association of the patients outside of school was unlikely. Homes and play areas were widely separated. These children were the first in their families to be diagnosed as having infectious hepatitis, as confirmed by personal interviews with the parents. Two of the cases were not interviewed because the families could not be contacted.

The interviews resulted in sufficient information to conclude that certain conditions existed in the school which could well have been the source of transmission. Some of the practices regarding the cafeteria and rest rooms were to be more carefully investigated. Some of the children worked in the cafeteria during lunch hours. One of the infected girls, subsequently diagnosed infectious hepatitis, had been assigned to a service squad to assist the younger children with eating such as removing caps from bottles of milk and cutting their meat for them. The cafeteria did not supply straws and the children drank directly from the pouring lip of the milk bottle. In addition, the half pint bottles of milk were not hooded and the cases were placed where they were easily accessible to the children. Another infected pupil sold candy in the school

before diagnostic symptoms appeared. On June 1, 1953, the school held a field day for the first eight grades and some of the children worked in the food concessions.

The younger classes were lined up at specified times to use the rest room. One of the girls stated that several girls would use a washbowl at the same time and that often there was not enough soap. Another pupil said that, although they used the flush method for washing, the bowls drained slowly so that other girls would wash their hands in the water remaining in the bowls. This information was acquired from interviews with the patients and not from the writer's inspection of the school facilities since school was closed at time of the investigation.

As stated previously, the first cases were children from rural areas whose homes were located a considerable distance from those of their schoolmates. It is conceivable, therefore, that once the infection gained entrance into the school, conditions existing there perpetuated it. Final conclusions were deferred pending completion of this study.

The second group encountered was that found in Milan. The first case appeared on March 1, 1953, in a sixteen-year-old boy who attended Milan High School. Since there had been no previous reported cases in Milan in 1952-53, we attempted to ferret out the source of his infection by talking with the family. The only information obtained was that the boy worked on his uncle's farm near Saline on weekends and was a member of the Saline 4-H Club. One family living about two miles from the farm where the boy worked, had had three cases of infectious hepatitis (the mother and two children). The first of this family's cases occurred about two weeks before the boy became ill. The boy was not acquainted with the family and had never had any known contact with them.

The boy's fourteen-year-old sister contracted the same infection with the onset appearing about April 1, 1953. Another Milan boy had occasional contact with the girl and became ill on June 1, 1953. During this period five other cases occurred in Milan. Of these seven patients, five attend Milan High School and two are pupils at Milan Elementary School. Any contact among the last four patients and the first three could not be verified. Personal contact, directly or indirectly, might have been responsible for the transmission.

In the Saline area the majority of infectious hepatitis cases were found in three families, all of whom were related. To simplify discussion a letter is used to designate each of the families—A, B, and C. Madames A, B, and C are sisters and each

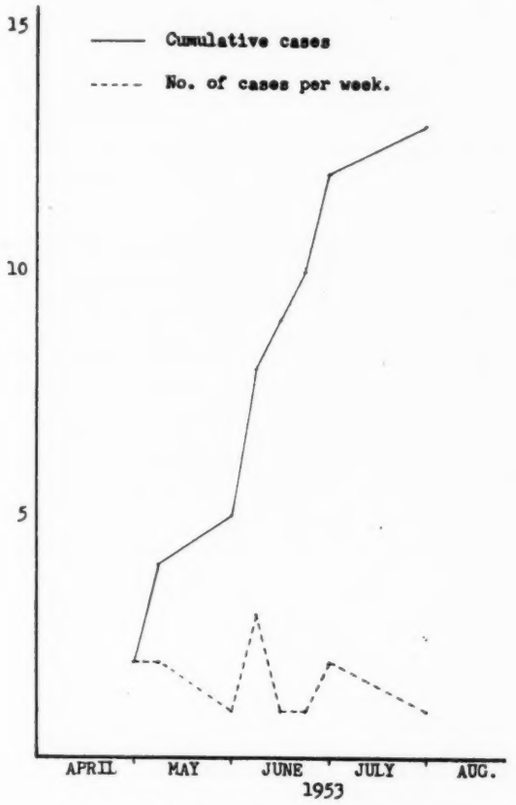

Fig. 2. Infectious hepatitis cases in combined elementary and high school A.

one has her own family. The A family lives north of Saline and the B and C families reside in the city of Saline. A brother-in-law of the sisters, who lives south of Milan in Monroe County, had the onset of infectious hepatitis January 1, 1953. The three sisters visited him on several occasions during his illness. On February 15, 1953, Mrs. A became ill with infectious jaundice and within five days two of her children also had the infection. Mrs. A remained at home, Mrs. B took care of her. Mrs. B became ill on March 15, 1953, and was confined to her home. Then Mrs. C cared for Mrs. B, only to contract infectious jaundice one month later, April 19, 1953. Within a span of twenty days, Mr. C and their two children became afflicted by the same disease. These cases, too, might have been the result of person-to-person transmission through close association.

(Continued on Page 1442)

Inguinal Shutter Herniorrhaphy

A Twelve-year Study of Related Factors and Results

By Earl G. M. Krieg, M.D.
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THE material published in January, 1953, pointed out that the problem of inguinal hernia was not a simple one.[2] We have found that a change in approach to the problem has resulted in a considerable reduction in unsatisfactory results.

We have brought together here all factors found inside and outside of the operating room, with which we were familiar, that have contributed to a successful operation. Certain clinical conditions were found that influenced the choice of technical procedures. The repair of defects in the anatomy of the entire inguinal area, and the decision to reinforce tissue layers, were problems that demanded individualization. In contrast, the fixation of the inguinal shutter was a routine procedure.

Our methods are presented in the order that they appeared in the management of our cases.

1. Preoperative Evaluation

It was evident that clinical observations could be used to advantage that were obtained by no other form of examination.

A thorough history, a careful examination, and all necessary laboratory work were important and, on occasion, revealed an unrelated state that precluded operation at that time. Our principal concern in the aged was the condition of the cardiovascular-renal system. The clinical findings influenced the choice of anaesthesia; spinal and local infiltration were preferred. Details of the local examination need not be discussed here; we preferred the standing position and carefully searched the opposite side for unsuspected pathology. Recently, Knott[1] has emphasized the possibility of occult hernia on the opposite side due to developmental symmetry. In our dissections for bilateral hernia, it was often noted that the anatomical and pathological conditions were identical on each side.

Habitus offered an advanced clue to inherent tissue strength. The individual of hypersthenic habitus had heavy tissue planes that infrequently required more than formal reparative procedures. Comparatively, the individual of hyposthenic habitus often exhibited thin structures that not infrequently required reinforcement, especially when associated with other factors noted in Part 4.

The physiological age of the older individual was often a barometer of tissue strength and reaction to operation. The eighty-year-old person who came into the office like one of fifty or sixty years of age usually had tissues and recovery powers of superior quality to that of the apathetic patient who had the appearance and actions of one twenty years older.

Senile changes in tissue layers were expected in all patients over forty years of age and were best evaluated grossly during the stage of dissection. In association with Dr. C. I. Owen, pathologist of Grace Hospital, 100 cases of all ages had local biopsies of muscle and fascia. He was unable to demonstrate microscopically any relationship between hernia and tissue changes due to congenital, traumatic or senile causes. This disappointing study indicated that biopsy would not evaluate tissue strength.

Lowered powers of tissue healing were roughly ascertained by studies of the blood serum protein and ascorbic acid levels when the history suggested any change from the normal. This condition was found most often in chronic disease of any nature and more specifically in chronic alcoholism, diabetes, dietary deficiencies, hypothyroidism, physical inactivity, senility and recurrent hernia noted shortly after operation.

The degree of physical effort expended at work and/or play was an important determinant among those reviewed when reinforcement of tissue planes was believed to be necessary (see Part 4).

Allergy due to suture materials occurred infrequently, but there were disturbing instances due to cotton, silk and stainless steel. If the patient had had a previous operation, the behavior of the wound after operation might be informative. We have used metal sutures for herniorrhaphy for the last ten years, and only three cases developed tissue reaction. In one of these it was necessary to completely remove the wire. A decided advantage of metal sutures was that they remained *in situ* in severely infected wounds.

2. Technical Considerations

Proper exposure, demonstration, and evaluation of the defects that may be present were made only through an adequate incision and by thorough dissection of the various components of the inguinal region.[2]

All defects were corrected so that the inguinal region was restored to as normal a condition as possible. The indirect sac was removed. The direct sacs (inguinal, interstitial and Spigelian) were inverted and the apertures closed. The triangular fascia was reattached to the rectus fascia which restored the inguinal floor and internal hiatus. The femoral canal was closed when necessary. Theoretically these reparative procedures would seem sufficient but they only prepared the field for the maneuvers described in Parts 3 and 4 which were basically designed to prevent recurrences. This statement contains the philosophy of our approach to the entire problem.

At this stage the surgeon must have correlated and appraised all clinical, anatomical and pathological factors related to the patient's problem. The sum total of these factors were translated into, first, whether or not a patch was indicated, and, second, the method of closure to be used.

3. Reinforcement of Tissue Planes

The approach to the problem of patches became clearer to us through studies in anatomy and tissue changes due to congenital, traumatic and the normal aging processes. All three changes may be present. Hitherto, the patch had been considered as an additional technical maneuver which made for a "better operation," and the indications for its use were rather vague. Now, the patch was used objectively to reinforce specific weaknesses in tissue planes. Several facts became evident. First, it would be necessary to formulate definite indications for the use of a patch. Second, clinical factors made their appearance which were evaluated outside the operating room. Third, the decision to use a patch advanced in geometrical ratio to the number of faults that were present. Fourth, these deliberations posed a problem in clinical judgment which improved with experience.

The following conditions, up to the present writing, were considered as indications for possible tissue plane reinforcement. On occasion one of these conditions alone was sufficient but usually a variety of combinations determined when the patch should be used.

1. Hyposthenic habitus.
2. Congenital hypoplasia or aplasia of the local tissues.
3. Heavy labor and/or violent exercise of any description.
4. Senile atrophy of the local tissues.
5. Trauma due to a large hernia or a previous operation.
6. Unilateral multiple hernias, particularly of the direct variety.
7. Bilateral hernias.
8. Local tissue atrophy due to a truss.
9. Pain following a successful repair (rare).
10. When clinical experience cast the least doubt as to tissue strength.

The Myers' operation provided the ideal foundation for the patch which was fashioned to cover the entire inguinal area. It extended over the symphysis pubis for a short distance for greater "purchase" and often measured 3 by 7 inches in area. At the point of emergence of the spermatic cord, a slit was made that corresponded in length to the cord's diameter and a suture was placed that closed the lower end of the slit, anchored it to the inguinal ligament and snugly enclosed the cord (Fig. 2). For the purpose, we used No. 35 or 36 gauge wire and plastic needles to avoid fraying the patch.

4. Closure of the Inguinal Region

Closure of the inguinal canal and the internal hiatus was routinely employed regardless of the type of hernia. This eliminated the shutter action completely. There were three variations of this method of closure, each designed to satisfy gross anatomical variations. The reader should note the extent of repair beyond (laterally) that accomplished by the classical methods of Bassini, Halsted, Ferguson and McVay. This point is of extreme importance.

Certain technical details were deemed necessary to fulfill a successful operation. (1) All anchoring sutures must be of non-absorbable materials. (2) Fascia to fascia approximation must be accomplished; on occasion, the minor division of the internal oblique muscle (above canal) was excised to accomplish this; aplasia of the rectus fascia was the only condition in which this was not possible. (3) Placement of sutures in the rectus fascia must be 1 or 2 centimeters above its lower border (Bassini). (4) The cremaster muscle should be sectioned at its origin. (5) Relaxing incisions in the rectus fascia should be made at the line of insertion of the external oblique aponeurosis at the least

sign of tension. (6) The suture which closed the leaves of the external oblique aponeurosis should bite into the tissues below to form a more solid wall; this was not necessary when a patch was used. (7) The spermatic cord should project through the wall at the level of the femoral vessels and reside in the subcutaneous tissues.

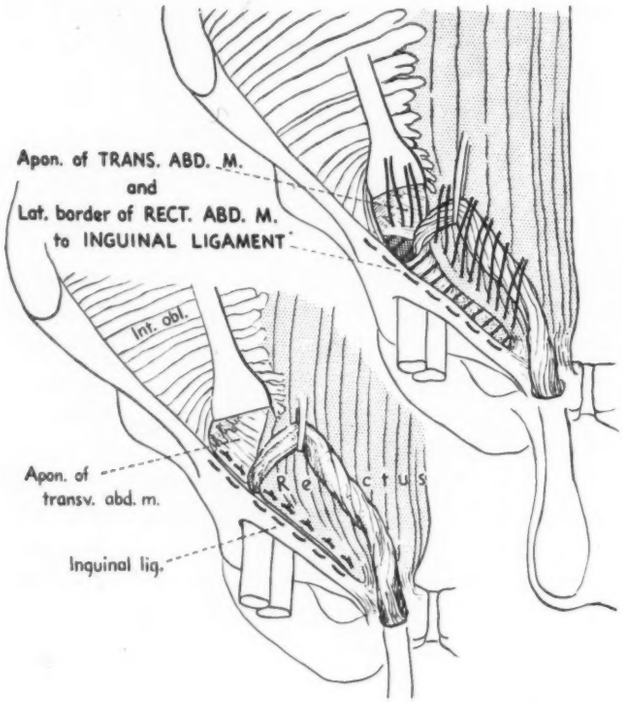

Fig. 1. The rectus fascia is anchored to the inguinal ligament from the pubis to the level of the femoral vessels above which the spermatic cord makes its exit. The transversus abdominis aponeurosis has been exposed, and it is fixed to the inguinal ligament behind the internal oblique muscle, completely closing the internal hiatus; this line of sutures may reach the ilium. The cord is snugly surrounded.

Variation One (McLaughlin).[3]—This method disturbed the normal anatomical relationships the least. Its use was limited, (a) to patients with well developed tissue layers, (b) when the transversus aponeurosis was well developed and at least two centimeters in length and (c) when no patch was required. Most patients in this class were under forty years of age and of hypersthenic habitus. A large number of our early cases were routinely repaired by this method (Fig. 1).

Variation Two (Myers).—This method was indicated (a) when reinforcement by a patch was required, (b) when previous operation precluded definitive dissection and (c) when the transversus aponeurosis was inadequate or absent (Fig. 2).

Variation Three (Krieg).—This method was devised for those patients whose inguinal ligaments in the canal region were absent, deficient or frayed during previous operations. It was imperative to expose the femoral vessels and nerve to direct vision before a single suture was placed. We have found four cases in which these vessels were next to the symphysis pubis (Fig. 3).

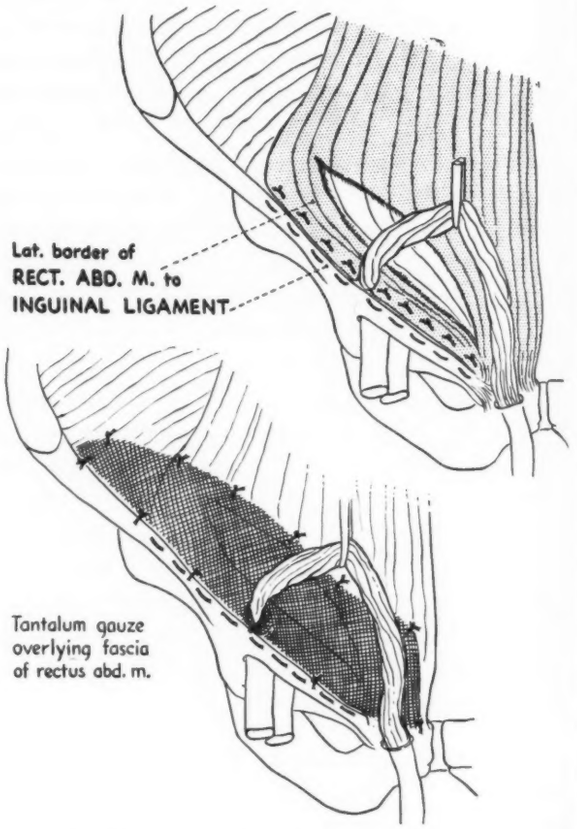

Fig. 2. The rectus fascia is anchored to the inguinal ligament from the pubic spine to within 1 or 2 centimeters of the iliac spine. A relaxing incision of adequate length may be needed as shown here; the rectus fascia is incised at its junction with the external oblique aponeurosis; when the sutures are tied, the internal oblique muscle disappears behind the line of repair.

The lower drawing illustrates a patch of proper size; it extends medially over the symphysis for 1 or 2 centimeters, laterally to the region of the ilium and superiorly as high as possible. The exit of the spermatic cord is well illustrated.

5. Post-Hospital Care

Routine exercise was begun immediately following hospitalization. We placed particular stress on this part of the management of each patient because it improved local muscular tone and general well being. The patient was asked to maintain a

schedule of walking at specific times twice daily for at least two weeks, preferably longer. Each day the distance was increased subject to his physical ability.

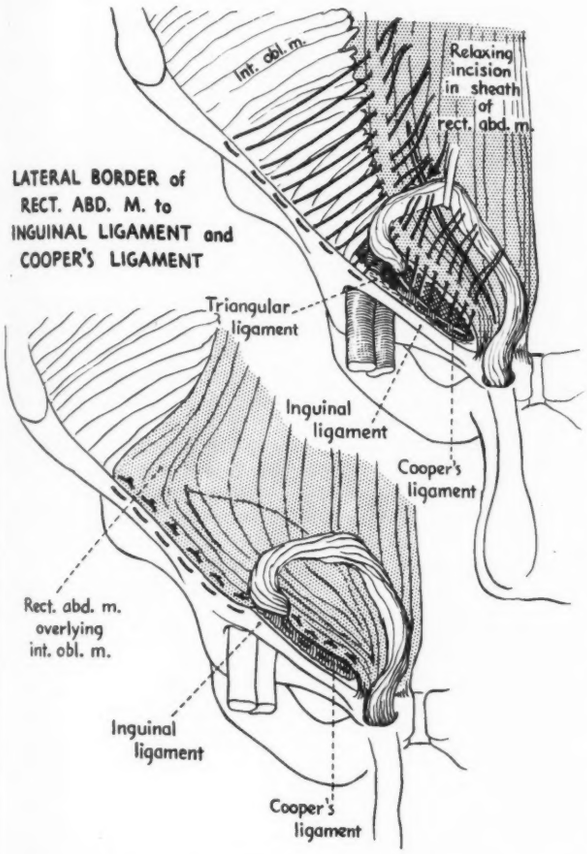

Fig. 3. Under direct vision, the rectus fascia is sutured to the superior pubic ligament (Cooper) as close to the femoral vessels as possible. Above the vessels and spermatic cord, the rectus fascia is sutured to the inguinal ligament, as shown here, which is similar to Variation Two, or the transversus aponeurosis may be used as in Variation One.

An elastic athletic supporter with a 6-inch belt often gave comfort. A hot tub bath just before retiring was beneficial, especially to the older group.

Return to sedentary work was permitted at any time; to heavy labor, in six weeks.

Statistics

Our follow-up, which was completed in January, 1954, has included all cases; none was included that had been operated upon for less than two years. There were 651 hernias; no women or children were included. Three patients had died.

The ages at the time of operation varied from twenty to eighty-seven years; 58.75 per cent were over fifty years of age.

Single hernias appeared on the right in 53.5 per cent and on the left in 46.5 per cent. Bilateral hernias were repaired in 118 cases (19.6 per cent) in the combined groups.

Sixty-two patients (10 per cent) came to us with recurrences who had been operated upon elsewhere. Eight had had bilateral repairs followed by recurrences on one side (right, five; left, three). Twenty-nine had had one previous repair on the same side (right, twelve; left, seventeen). Three patients had had two previous repairs and two had had three previous repairs on the same side (right). Fourteen patients had had bilateral recurrent hernias; seven had had a single hernia repaired before the first bilateral repair. Nine patients had had one side repaired with subsequent appearance of a hernia on the opposite side. There were twenty-nine cases (almost one-half of the whole group) that exhibited the recurrent indirect variety; eight of these were sliding hernias and three had large lipomata projecting through the hiatus.

Comment.—A review of the individual problems of the patients presented in this maze of statistics bolstered our belief still more that the major aspect of the problem resolved itself into two main issues: (1) recognition and prevention of the breakdown of inadequate tissues, and (2) complete closure of the inguinal region which included the internal hiatus. This latter procedure eliminated the recurrent indirect hernia in our series.

Results

Our results are reported in two groups. The patients in Group 1 were largely industrial workers who had had 540 hernias repaired between September, 1942, and June, 1948. Surgery comprised the repair of local defects enumerated in Part 2 and the closure of the inguinal shutter described in Part 4. Bilateral hernias were repaired ninety-four times (16 per cent) in this group. There have been nine recurrences, four were single direct hernias which appeared after bilateral repair and five appeared after single repair. The total recurrence rate for this group has remained at 1.5 per cent, and none has recurred thus far that was repaired after 1946. In a critical review of these recurrences we believed that these cases were examples of direct recurrences due to breaking down of inadequate tissue layers that should have been reinforced by a suitable patch. Experience suggest-

ed that an occasional recurrence should still be expected in this series.

The patients in Group 2 were all private patients who were not comparable to those of Group 1 in many instances due to sedentary occupations. They had had 111 hernias repaired between June, 1948, and June, 1952. They marked the beginning of definitive, routine evaluation of tissue layers according to our methods and the application of a patch when necessary; the repair of local defects and the closure of the shutter was done as before. Bilateral hernias were repaired in twenty-four cases (22 per cent). Patches were inserted in fifty-seven sides; tantalum mesh, forty-six times; stainless steel, eight times, and full thickness cutis grafts, three times. No recurrence has occurred in this group thus far.

Conclusions

1. A change in approach to the problem of hernia from that of the classical methods of repair is desirable.
2. Related clinical factors must be considered.
3. Postoperative reconditioning through exercise is desirable.
4. Repair of the local defects and closure of the inguinal shutter has resulted in a recurrence rate below 2 per cent in 540 hernias operated upon between 1942 and 1948.
5. Our present technique, which involved (1) repair of the local defects, (2) closure of the inguinal shutter and (3) recognition and reinforcement of inadequate tissue layers, has resulted in no recurrence in 111 hernias operated upon between 1948 and 1952.

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INFECTIOUS HEPATITIS IN WASHTENAU COUNTY, MICHIGAN

(Continued from Page 1437)

Conclusions

Certain conclusions are derived from an evaluation of the data so far accumulated in this study. The following statements are based on the tablulated data and impressions received by interviewing the patients in their home environment.

1. From January 1 to August 1, 1953, infectious hepatitis reached epidemic proportions in Washtenaw County, Michigan.
2. Preliminary investigation has failed to show any specific channel for the spread of the cases reported.
3. In a significant number of cases transmission of the cases reported was associated with intimate patient-to-patient contact.
4. In a significant number of cases transmission of the cases reported was associated with violation of certain basic sanitary principles in a school.
5. The relationship of school sanitary practice, the spread of infectious hepatitis, and possible remedial measures merits further study.
6. In Washtenaw County, city and village residents infected with infectious hepatitis demontrated a pattern of free movement through rural areas or contact with infected persons from rural areas during the incubation period of the disease. The same held true for rural residents, city visits, and contacts. Proper rural and fringe sanitation facilities would seem to be of concern to those who reside in cities and villages and vice versa.

Acknowledgment

The writers wish to express their appreciation and gratitude to the doctors, patients and hospitals of Washtenaw County for their interest and co-operation in this study. Special thanks is extended to Dr. F. M. Hemphil, University of Michigan School of Public Health, for helpful suggestions regarding the scope of the investigation, and the presentation of the data and material.

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A Page from Medical History

III. Egypt

By John E. Summers, M.D.
Grand Rapids, Michigan

Thou shalt not abhor an Edomite: for he is thy brother: thou shalt not abhor an Egyptian; because thou wast a stranger in his land.—DEUT. 23:7.

"Moreover also the answer given by the Oracle of Ammon bears witness in support of my opinion that Egypt is of the extent which I declare it to be in my account; and of this answer I heard after I had formed my own opinion about Egypt. For those of the city of Marea and of Cysis, dwelling in the parts of Egypt which border on Libya, being of opinion themselves that they were Libyans and not Egyptians, and also being burdened by the rules of religious service, because they desired not to be debarred from the use of cow's flesh, sent to Ammon saying that they had nought in common with Egyptians, for they dwelt outside the Delta and agreed with them in nothing; and they said they desired that it might be lawful for them to eat everything without distinction. The god, however, did not permit them to do so, *but said that that land was Egypt which the Nile came over and watered, and that those were Egyptians who dwelling below the city of Elephantine drank of that river.*" (Herodotus).*

THE modern races of mankind have been present on the earth's surface for thousands of years. In certain areas of the world conditions were such as to make possible the advancement of man from the *food-gathering* stage of Early Stone Age savagery to the stage of food-production. *Food production* (first meaning the domestication of wild animals) requires a system of irrigation, which depends upon an organized government, which in turn requires *records* (writing) and a *calendar*. *Agriculture* on a large scale and *plentiful metal* are necessary for the development of civilization.

The rich "bottom" land of certain rivers formed the laboratories of our civilization. Along the Tigris and Euphrates rivers the Babylonian civilization and along the Nile river the Egyptian civilization developed. Even at the present time most of the people in China are crowded along the banks of the Yangtze river and the people of India try to secure life from the Ganges.

Fig. 1. Origin of the Rx. *Horus*, the god of health in a fight with *Set*, the demon of evil, lost an eye, which, by magic, was restored. The eye of Horus formed the design for a charm or amulet second only to the sacred dung beetle (scarab). The eye of Horus, after passing through various phases, became conventionalized as something resembling Rx and was placed on objects associated with danger, such as chariots, ships and prescriptions.

The few favored geographical areas where life could be maintained easier have always been in demand. In our consideration of the development of civilization it should be remembered that outside of the circumscribed spotlight of our attention restlessly mill the multitude of less favored members of mankind. In their desire to seek the more fruitful way of life they continually and everlastingly push themselves into the fringes of our spotlight, to be driven back time and time again by the "rightful inhabitants" but eventually to overwhelm the latter. Thus the ancient civilizations have followed a general pattern: (1) a prolonged period of development and expansion, (2) a short period of greatest political domination permitting the culture to attain its maximum, (3) a period of dismemberment, invasion and decline. So it was with Egypt.

The Nile river is the longest river in the world. It is 4000 miles long and consists of three main divisions: (1) the main stream running south to north and fed by the great lakes of East Central Africa, (2) the equatorial tributary rivers draining the country northeast of the Congo Basis, (3) the Abyssinian affluents.[6] Lake Victoria, 3,704 feet above sea level, is the main reservoir feeding the Nile. The Abyssinian affluents are the source

*Herodotus (c. 484 to 425 B.C.) called "the father of history" was born in Halicarnassus in Asia Minor which at that time was ruled by the Persians. His history which was written c. 445 B.C. was so highly approved by the Athenians that he was voted a gift of ten talents (2,400 lbs.). He was unable to secure his citizenship in Athens as the franchise in Athens was difficult to obtain and so sailed to Thurii with other Greek colonists. His work consists of nine books, the first six of which serve as an introduction to the last three which deal with the great Persian wars of invasion.

of the annual Nile flood, which has been recorded each year since 3600 B.C. The Nile traverses the Nubian desert and during the last 1600 miles of its course does not receive a single tributary.

Fig. 2. The Rosetta Stone. When Napoleon set sail in May, 1798, on his expedition to Egypt he carried with his a large group of scientists to explore the country. In 1799 Napoleon's soldiers found, near the Rosetta mouth of the Nile river a stone 3 feet 9 inches long, 2 feet 11 inches wide and 11 inches thick which had writing on its smooth side. This writing was divided into three columns: (1) Hieroglyphics, (2) Demotic (the script writing of the hieroglyphics), (3) Greek. The Greek column was immediately translated but only after twenty years of work was Jean-Francois Champollion able to decipher the hieroglyphics. After this the miles of hieroglyphics in the temples, tombs and coffins up and down the Nile began to speak and tell us about that remarkable civilization. In September, 1801, when the English beat the French at Alexandria they took over Napoleon's pharaonic antiquities; now the Rosetta Stone is in The British Museum. *(Photograph obtained from The British Museum).*

Consequently, as it passes through the hot and rainless Sahara desert it decreases in volume. The annual overflow of the Nile, the cause of which the ancients pondered greatly, as recorded by Herodotus, deposits rich sediment brought from the Abyssinian highlands creating the delta and the fertile strip that is Egypt. So rich and fertile is this strip of land, and especially the delta, that today the average Egyptian farmer grows three crops each year on his one acre. As there is no rain, irrigation is essential now as it always has been.

A line drawn just south of Cairo divides the country into lower Egypt (the delta) and upper Egypt (the Nile valley). In upper Egypt the Nile valley is very narrow and is bounded by mountains of no great height. They form the edge of the desert on either side of the valley, of which the bottom is level rock. The bright green of the fields, the reddish-brown or dull green of the great river contrasting with the bare yellow rocks, seen beneath a brilliant sun and a deep-blue sky, present views of great beauty.[6]

Due to the preservative climate of Egypt the science of archeaology developed there and was subsequently applied to Babylonia, Greece, Rome, and throughout the world. "In the last century and a half, millions of cubic yards of the soil of Egypt have been moved and sifted. Thousands of its native population have worked their lifetimes in its multitude of 'digs,' and hundreds of ships have sailed from its harbors, laden with antiquities for the museums and private collections of the five continents. Yet today, the old mine shows not the slightest sign of being exhausted."[7]

The history of ancient Egypt is divided into three main periods.[4]

1. *The Pyramid Age,* from about the 30th to 25th Century B.C. revealed by the cemeteries (pyramids and other tombs) of Gizeh.

2. *The Feudal Age,* which flourished around 2000 B.C. and is revealed by the cliff-tombs and the papyrus-roll libraries.

3. *The Empire* (called the Golden Age) existed about 1580 to 1150 B.C.; revealed by the temples and cliff-tombs of Thebes (Karnak).

The decipherment of the acres of hieroglyphics which cover the coffins, tombs, pyramids, obelisks, temples, and papyrus rolls followed the discovery and decipherment of the famous Rosetta Stone.

The Pyramid Age

30th to 25th Centuries B.C.

During this period lower and upper Egypt were united under one king (Menes), extensive irrigation was developed, oxen were yoked, the copper mines in the Peninsula of Sinai were exploited and sixty miles of royal pyramids and tombs, ex-

tending from Gizeh (Memphis) into the desert, were built. The inscriptions, pictures, reliefs, and sculptures in these pyramids and tombs tell the story of agriculture, cattle raising, oxen, donkeys, *in 4236 B.C. This is the earliest dated event in human history.*[3,4])

Of the great pyramid of Gizeh which was being built c. 2835 B.C. Herodotus tells us.

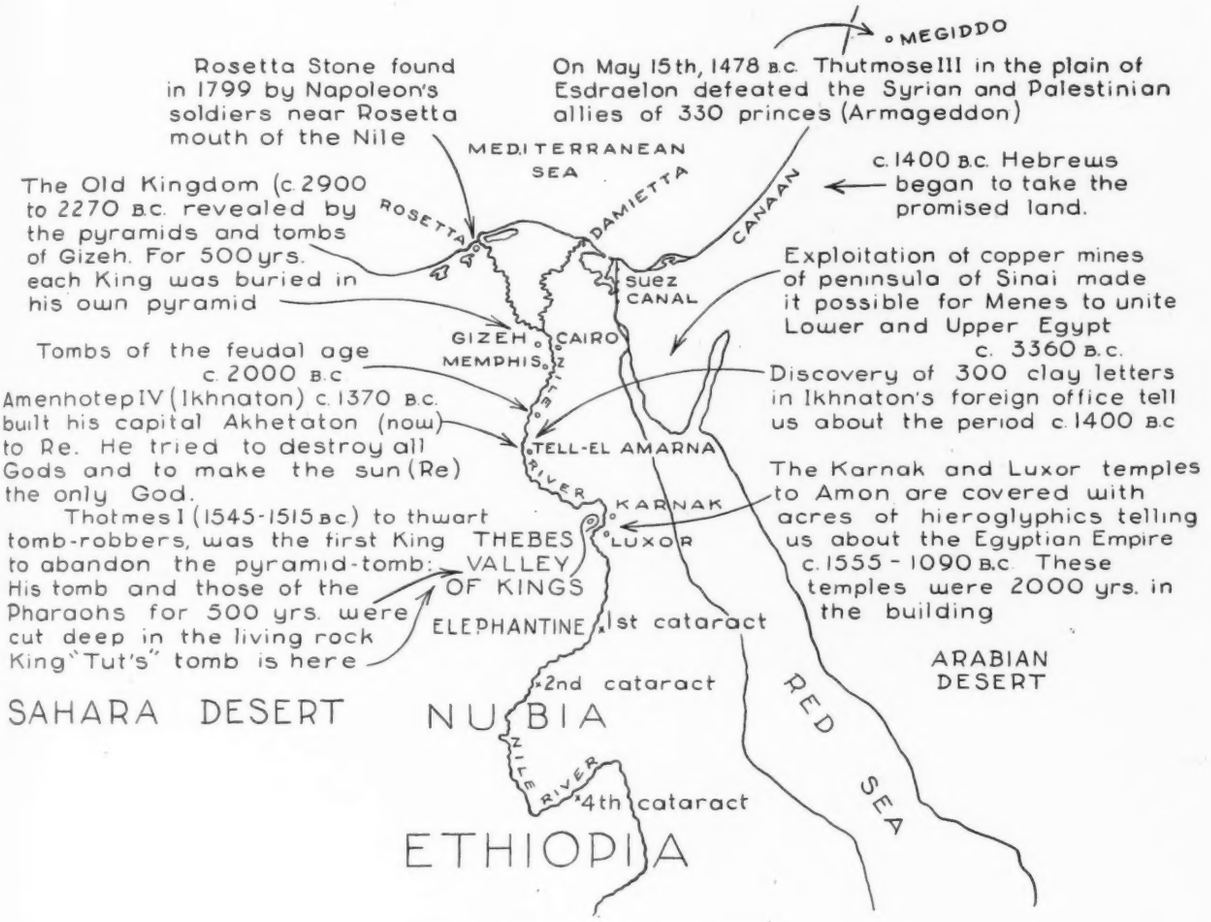


Fig. 3. Diagram of Ancient Egypt.

The Nile river flows north through the hot and rainless desert to empty into the Mediterranean Sea. At the beginning of the delta, the Nile separates into two channels, the Rosetta and the Damietta, which empty into the Mediterranean Sea at its southeast angle. The annual overflow of the Nile produces a fertile strip of land on either side of the river. As there is no rain, irrigtation has always been necessary. A line drawn just south of Cairo divides the country into lower Egypt (the delta) and upper Egypt (the Nile valley). The old kingdom had its capital at Gizeh. During the period of greatest political domination (the empire), the capital was at Thebes.

coppersmiths, lapidary art, goldsmiths, jewelers, potter's wheel and furnance, early glass, weaving, tapestry-makers, paper makers, carpenters and cabinet makers, shipbuilders, river commerce, barter (there was no coined money), kings, nobles, priests, soldiers, freemen, slaves, life on the nobles' estates, captive nations bringing tribute to the Pharaoh and, above all, tribute to the gods.

The calendar (consisting of 12 months of 30 days each plus 5 added feast days, was introduced

". . . but after him (Min, the first king of Egypt) Cheops became king over them and brought them to every kind of evil: for he shut up all the temples, and having first kept them from sacrifices there, he then bade all the Egyptians work for him. Some were appointed to draw stones from the stone-quarries in the Arabian mountains to the Nile, and others he ordered to receive the stones after they had been carried over the river in boats, and they worked by a hundred thousand men at a time—of this oppression there passed ten years while the causeway was made—for the making of the pyramid itself then passed a period of twenty

years. The wickedness of Cheops reached to such a pitch that when he had spent all his treasures and wanted more, he sent his daughter to the stews with orders to procure him a certain sum, how much I cannot say, for I was not told; she procured it, however, and

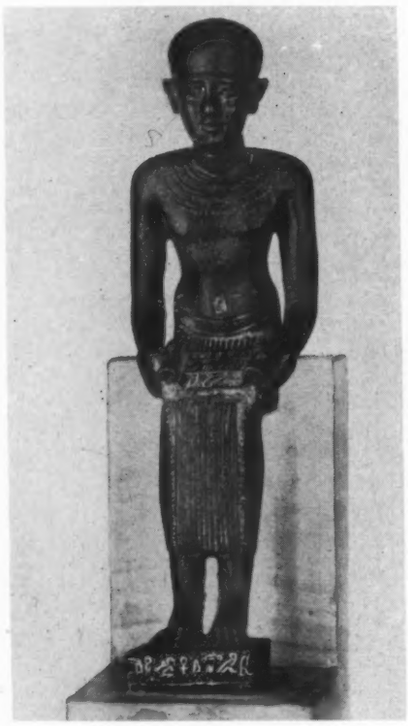


Fig. 4. Statuette of Imhotep, Physician and Vizier to King Zoser c. 2980 B.C.

Imhotep was vizier, architect, chief ritualist, sage and scribe under King Zoser who built the "step pyramid" of Sakskarah (the oldest surviving stone building in the world). Imhotep's healing was, reportedly, mostly magic. Imhotep was certified as a medical demigod during his life and about 2430 years later was promoted to the position of Full Deity of Medicine. The Greeks called him Imouthes and identified him with their God of Healing, Asklepios. *(Courtesy of the Wellcome Historical Medical Museum, London, England.)*

at the same time, bent on leaving a monument which should perpetuate her own memory, she required each man who sought intercourse to make her a present of a stone towards the works which she contemplated. With these stones she built the pyramid which stands midmost of the three that are in front of the great pyramid—thus the affliction of Egypt endured for the space of 106 years, during the whole of which time the temples were shut up and never opened. The Egyptians so detest the memory of these kings that they do not much like to mention their names."

So much then for the esteem which the Egyptians held for those kings who forced them to build the pyramids.

In almost every museum in this country there is some relic from Egypt. Mummies are very common. The ancient Egyptians did not embalm the dead so that they might have a space in our modern museums but rather that they might live forever. Concerning this art of embalming we have, again, to return to Herodotus.

"Their fashions of mourning and of burial are these. Whenever any household has lost a man who is of any regard amongst them, the whole number of women of the house forthwith plaster over their heads or even their faces with mud. Then leaving the corpse within the house they go themselves to an fro about the city and beat themselves with their garments bound up by a girdle and their breasts exposed, and with them go all the women who are related to the dead man, and on the other side the men beat themselves, they too having their garments bound up by a girdle. When they have done this, they then convey the body to the embalming. In this occupation certain persons employ themselves regularly and inherit this as a craft. These, whenever a corpse is conveyed to them, show to those who brought it wooden models of corpses made like reality by painting, and the best of the ways of embalming they say is that of him whose name I think it impiety to mention when speaking of a matter of such a kind; the second which they show is less good than this and also less expensive. The third is the least expensive of all. Having told them about this, they inquire of them in which way they desire the corpse of their friend to be prepared. Then they depart out of the way and the others being left behind in the buildings embalm according to the best of these ways thus: First with a crooked iron tool they draw out the brain through the nostrils extracting it partly thus and partly by pouring in drugs; and after this with a sharp stone of Ethiopia they make a cut along the side and take out the whole contents of the belly, and when they have cleared out the cavity and cleansed it with palm-wine they cleanse it again with spices pounded up; they then fill the body with pure myrrh pounded up and with cassia and other spices except frankincense, and sew it together again. Having so done they keep it for embalming covered up in natron for seventy days, but for a longer time than this it is not permitted to embalm it; and when the seventy days are past, they wash the corpse and roll its whole body up in fine linen cut into bands, smearing these beneath with gum, which the Egyptians use generally instead of glue. Then the kinsfolk receive it from them and have a wooden figure made in the shape of a man and when they have had this made they enclose the corpse and having shut it up within, they store it in a sepulchral chamber setting it to stand upright against the wall. Thus they deal with the corpse which is prepared in the most costly way."

We do not have very much evidence concerning the practice of medicine in Egypt during the pyramid age. The early Egyptians had many gods which they worshipped. The pyramid is a symbol

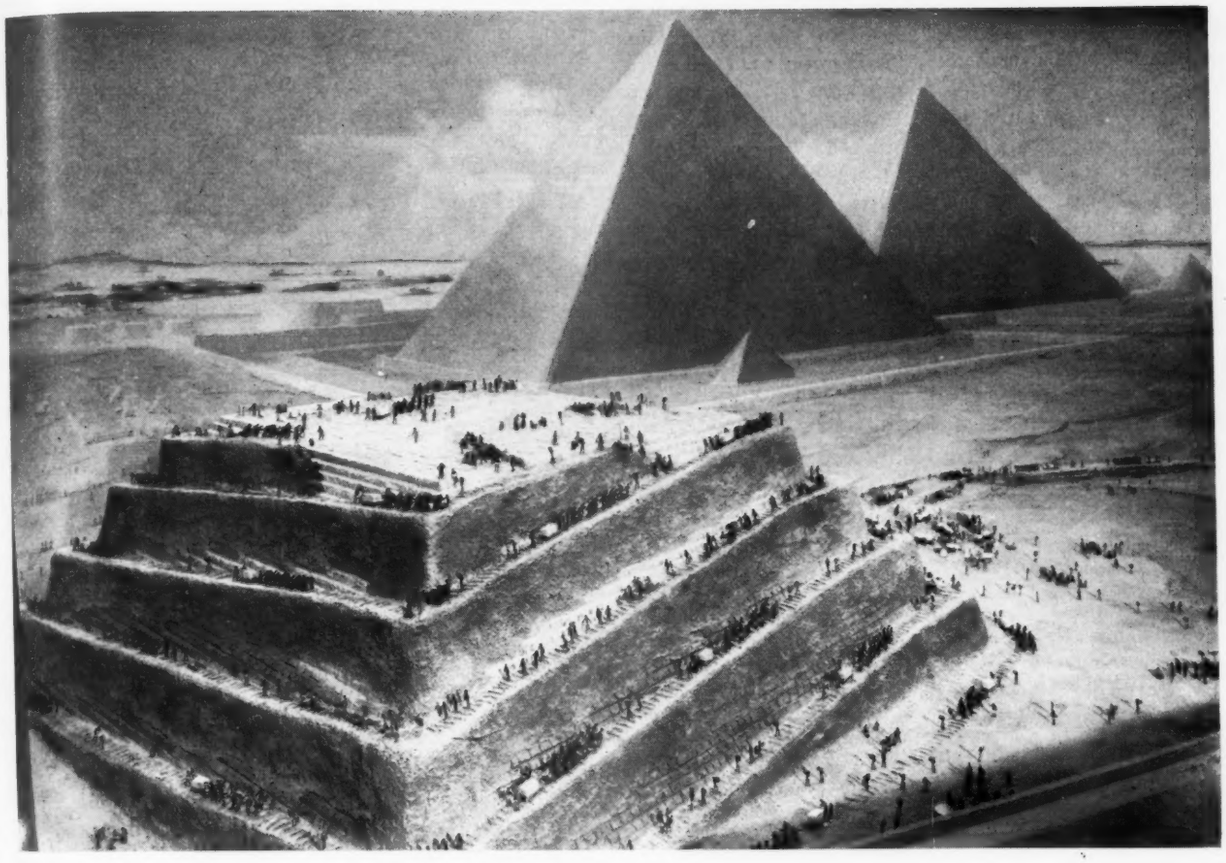


Fig. 5. The Construction of the Third Pyramid at Gizeh.

Photograph of a model at the Boston Museum of Science. Only the pharaohs had pyramids. The nobles had lesser tombs called mastabas. The common people were buried in the desert sand. The pyramids of the pharaohs of the Old Kingdom extend in a line over sixty miles long. One can only conjecture the tremendous amount of human labor expended on these huge rock tombs. Sixty-seven pyramids have been discovered. *(Photograph obtained from the Boston Museum of Science.)*

to the sun god, Re. They expected to continue to live after death so their many possessions were buried with the dead. Only the houses of the dead have survived for our study. The extant medical papyri may have been written during this period; our present ones being copies of the originals.

In regards to Imhotep who was vizier, architect, chief naturalist, sage and scribe under Pharaoh Zoser of the third dynasty (c. 2980 B.C.), there is no contemporary evidence that he was a physician. However, he acquired a wide reputation as a healer through magic and was promoted during life to the rank of demigod. Then under the Ptolemies he was made the Egyptian god of medicine. The Greeks called him *Imouthes* and identify him with their god of healing, *Asklepios.* Large numbers of statues and figurines of Imhotep have been recovered.

(The Feudal Age)

Circa 2000 B.C.

Due to the growth of power of the nobles the Pharaohs had to make many concessions to them. During this period pyramids as royal burial houses went out of fashion and in the cliffs back of their fertile valley estates the nobles excavated their tombs in the living rock. Books (papyrus rolls) written during those times on kindness and justice, drama, poetry, surgery, medicine, science, and mathematics have been found.

The Egyptian papyrus rolls of laws have perished so we do not have a "Hammurabi stone" for Egypt. Ideas of social consciousness were prevalent, however; one monarch had inscribed on the walls of his tomb:

"There was no citizen's daughter whom I misused, there was no widow whom I oppressed, there was no peasant whom I repulsed, there was no herdsman whom

I repelled, there was no overseer of self-laborers whose people I took for (unpaid) imposts, there was none wretched in my community, there was none hungry in my time. When years of famine came, I ploughed all the fields of the Oryx-nome, as far as its southern and northern boundary, preserving its people alive, and furnishing its food, so that there was none hungry therein. I gave to the widow as to her who had a husband: I did not exalt the great above the small in all I gave. Then came great Niles, rich in grain and all things, but I did not collect the arrears of the field."[11]

Yet some of the rulers, in order to thwart the awful judgment of Osiris when their guilty souls stood before him after death, had a sacred beetle (scarabaeus) cut from stone and inscribed with a charm, "Oh my heart, rise not up against me as a witness." And well might they need this charm in view of such complaints as the following:

"The worm hath taken half his corn (wheat), the hippopotamus the rest. Mice abound in the field, and the locust has descended. The cattle devour and the sparrows pilfer. Alas for the husbandman!

"The remainder that lieth upon the threshing-floor, the thieves have made away with it. The ploughshare of copper hath perished, and the yoke of horses hath died at the threshing and ploughing.

"And now *the scribe* landeth upon the embankment to register the harvest. His body guard carry sticks and his negroes palm switches. They cry, give up your corn. And there is none there. He is stretched out and beaten, he is bound thrown into the canal. His wife is bound before his eyes and his children put in fetters. His neighbors run away to look after their own corn."[13]

Scribes were great men in those days and were apparently allied against the people even in Christ's time because Christ said:

"Woe unto you, scribes and Pharisees, hypocrites! for ye devour widow's houses, and for a pretense make long prayer: therefore ye shall receive the greater damnation."—*St. Matthew,* 23:14.

The great majority of the surviving Egyptian literature consists of religious works. These consist of magical spells which help to get the Egyptians to "heaven." They have been classified as "Pyramid Texts" originating in the pyramid age, "Coffin Texts" written on the sides of the coffins during the feudal age, and the "Book of the Dead" written on papyrus rolls during the age of the empire.

The "Book of the Dead," consisting of magical formulas to assist the soul into the new life, allows us to see into the conscience of the noble. Pertinent quotations from the "Book of the Dead" are given:[12]

Homage to Thee, O Great God, Lord of the city of MAATI, I have come unto Thee, O my Lord, and I have brought myself hither that I may gaze upon Thy beauties.

I know Thee, I know Thy Name, I know the names of the forty-two gods who are with Thee in this Hall of MAATI, who live as the warders of sinners and who swallow their blood on that day of reckoning up the characters (or dispositions of men) in the presence of UN-NEFER (i.e., OSIRIS). In truth 'REKHTI-MERTI-NEB-MAATI is Thy Name.

Verily I have come upon Thee, I have brought unto Thee MAATI (i.e., TRUTH, or the LAW), I have crushed for Thee SIN.

1. I have not acted sinfully towards men.
2. I have not oppressed the members of my family.
8. I have not domineered over servants.
10. I have not filched the property of the lowly man.
13. I have not inflicted pain (or caused suffering).
14. I have not permitted any man to suffer hunger.
15. I have not made any man to weep.
16. I have not committed murder.
17. I have not given an order to cause murder.
20. I have not defrauded the gods of (their) cakes (or offerings).
22. I have not committed sodomy.
24. I have not made light the bushel.
26. I have not encroached upon the fields (of others).
27. I have not added to the weights of the scales.
28. I have not diminished the weight of the pointer of the scales.
29. I have not snatched away milk from the mouth(s) of children.
33. I have not made a cutting in a canal of running water.
39. I have not robbed.
40. I have not defrauded.
41. I have not uttered falsehood.
43. I have not blasphemed.
45. I have not uttered slanders.
46. I have not played the eavesdropper.
47. I have not lain with another man's wife.

Most of the knowledge of ancient Egyptian medicine depends upon the following papyri:

1. *Kahun Medical Papyrus* was written c. 1900 B.C. It is small, mostly illegible and deals with diseases of women, wandering of the uterus, methods of ascertaining pregnancy and the sex of unborn children.

2. *Edwin Smith Surgical Papyrus* was written c. 1600 B.C. This papyrus deals in a systematic manner, beginning with the head and progressing downward, with wounds, fractures, and disloca-

tions. The latter part of this papyrus has been destroyed, the last case presented concerns an injury of the spine.

3. *The Papyrus Ebers* was written c. 1550 B.C. It is the largest one and is complete. It does not deal with fractures but otherwise comprises all kinds of diseases.

4. *The Hearst Papyrus* consists of recipes, many of which are identical with those in the Papyrus Ebers.

5. *The Berlin Medical Papyrus* was written c. 1250 B.C. It contains recipes; it also deals with methods of ascertaining pregnancy and the sex of unborn children.

6. *The London Medical Papyrus* was written c. 1350 B.C. It contains some prescriptions but chiefly incantations against different diseases.

Of these papyri, the Edwin Smith Surgical Papyrus and the Papyrus Ebers are the most valuable.

The Edwin Smith Surgical Papyrus is fundamentally different from the other medical papyri. It consists of cases, not recipes. The cases are arranged systematically beginning with injuries of the head and progressing downward. Magic is resorted to in only one case out of the fifty-eight. Each case is classified as, favorable to uncertain, or unfavorable. From fifty-eight examinations, treatment is recommended in forty-two instances; in sixteen cases treatment is not recommended. Case 9 is the one case where magic is used:

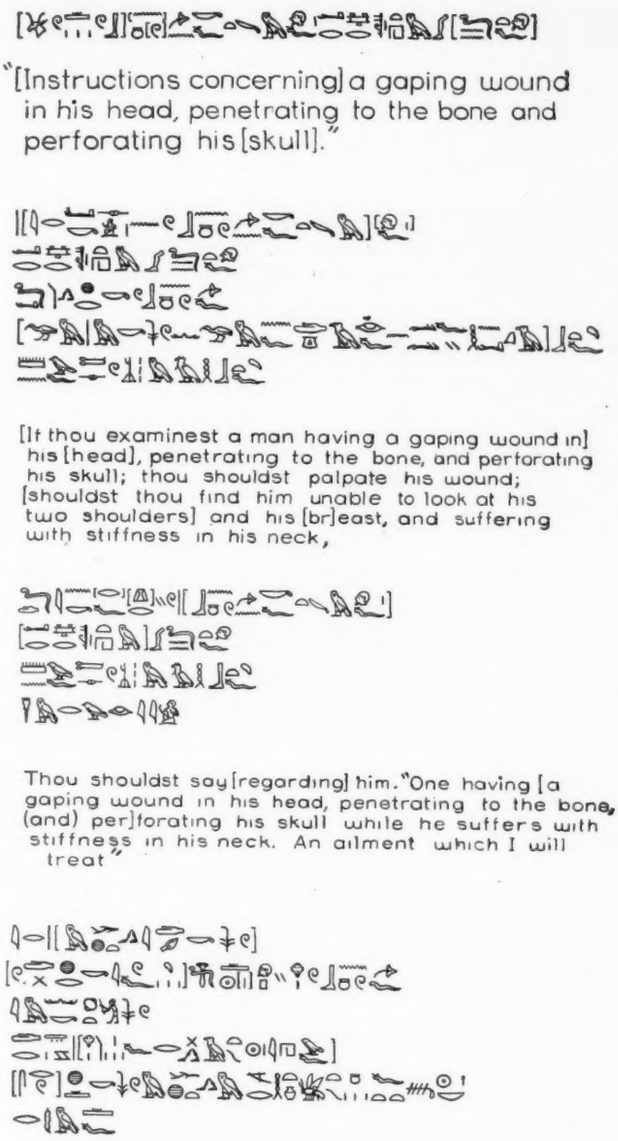
CASE NINE:[2]

Title.—Instructions concerning a wound in his forehead, smashing the shell of his skull.

Examination.—If thou examinest a man having a wound in his forehead, smashing the shell of his head (conclusion in treatment).

Treatment.—Thou shouldst prepare for him the egg of an ostrich, triturated with grease (and) placed in the mouth of his wound. Now afterward thou shouldst prepare for him the egg of an ostrich, triturated and made into poultices for drying up that wound. Thou shouldst apply to it for him a covering for physician's use; thou shouldst uncover it the third day, (and) find it knitting together the shell, the color being like the egg of an ostrich.

That which is to be said as a charm over this recipe:
Repelled is the enemy that is in the wound!
Cast out is the evil that is in the blood,
The adversary of Horus, on every side of the mouth of Isis.
This temple does not fall down;
There is no enemy of the vessel therein.
I am under the protection of Isis;
My rescue is the son of Osiris.



"[Instructions concerning] a gaping wound in his head, penetrating to the bone and perforating his [skull]."

[If thou examinest a man having a gaping wound in] his [head], penetrating to the bone, and perforating his skull; thou shouldst palpate his wound; [shouldst thou find him unable to look at his two shoulders] and his [br]east, and suffering with stiffness in his neck,

Thou shouldst say [regarding] him. "One having [a gaping wound in his head, penetrating to the bone, (and) per]forating his skull while he suffers with stiffness in his neck. An ailment which I will treat"

Now [after thou hast stitched it, thou shouldst lay] fresh [meat] upon his wound the first day. Thou shouldst not bind it. Moor (him) [at his mooring stakes until the period of his injury passes by]. Thou shouldst [tre]at it afterward with grease, honey, and lint every day, until he recovers.

Fig. 6. A case history from The Edwin Smith Surgical Papyrus. This surgical treatise was written on payrus in the manuscript or rapid writing form of hieroglyphics called hieratic. Breasted transliterated it to hieroglyphics as shown here. Each case was divided into four main parts: (1) Title, (2) Examination, (3) Diagnosis, (4) Treatment. Breasted believes that this surgical manuscript originated in the Old Kingdom period of Egypt.

Now afterward thou shouldst cool (it) for him (with) a compress of figs, grease, and honey, cooked, cooled, and applied to it."

CASE TWENTY-EIGHT:[2]

Title.—Instructions concerning a wound in his throat.

Examination.—If thou examinest a man having a gaping wound in his throat, piercing through to his gullet; if he drinks water he chokes and it comes out of the mouth of his wound; it is greatly inflamed so that he develops fever from it; thou shouldst draw together that wound with stitching.

Diagnosis.—Thou shouldst say concerning him: one having a wound in his throat, piercing through to his gullet. An ailment with which I will contend.

First Treatment.—Thou shouldst bind it with fresh meat the first day. Thou shouldst treat it afterward (with) grease, honey, (and) lint every day, until he recovers.

Second Examination.—If, however, thou findest him continuing to have fever from that wound, (conclusion in following second treatment).

Second Treatment.—Thou shouldst apply for him dry lint in the mouth of his wound, (and) moor (him) at his mooring stakes until he recovers.

The Papyrus Ebers consists mostly of recipes heavy on the carthartic side. There are a few examinations recorded; there are references to nineteen separate examinations dealing with: a "liver-case," a weak digestion, chest complaint with fetid expectorations, angina pectoris, catarrh of the nose with conjunctivitis, a fit of shivering, a case of bubonic plague, hemorrhage of the stomach, accumulation of fluid in the stomach, disease of the back, uremic cramps with dropsy, abdominal pain in the right side, enlargement of the spleen, ankylostomiasis, a serious wasting disease.

Chest Complaint with Fetid Expectoration.[5]—"If thou examinest a man with an obstacle, and he produces expectoration (lit. what is lifted by cough), and his disease under his breast sides is like a latrine-cave (then thou shalt say thereof): It is (due to) accumulations in his breast sides, it is narrow for his cardia. Thou shalt prepare for him strong remedies to drink; fresh porridge, boiled with oil and honey . . . and . . . is added to it, they are boiled together and drunk for 4 days. If thou examinest him afterwards and findest him in his disease of the first time (?), it shows that he will get well."

Also from the Papyrus Ebers we have:

Recital on Drinking a Remedy.—"Come remedy! Come thou who expellest (evil) things in this my stomach and in these my limbs! The spell is powerful over the remedy. Repeat it backwards! Dost thou remember that Horus and Seth have been conducted to the big palace at Heliopolis, when there was negotiated of Seth's testicles with Horus, and he shall get well like one who is on earth. He does all that he may wish like these gods who are there. Spoken when drinking a remedy. Really excellent, (proved) many times!"

Ebell believes that the Greeks obtained much of their medical knowledge from the Egyptians.

The feudal age in Egypt was brought to an end by the invasion of the Hyksos. These people introduced, among other things, the horse into Egypt.

The Empire Age

Circa 1580 to 1150 B.C.

Following the expulsion of the Hyksos by Ahmose I, the Pharaohs organized great armies of archers and chariots and became imperalistic. At this time the greater part of the land, with the exception of that owned by the priest order, was the personal property of the Pharaoh. The Hebrews later recorded that this came about during the viziership of Joseph. After Joseph had been sold into slavery into Egypt he prospered and was advanced by the Pharaoh. After the affair between Joseph and the Pharaoh's wife *(Gen.,* 39:7-23) Joseph was cast into prison. After interpreting his cell-mates' dreams he gained a reputation for dream interpretation and later interpreted the Pharaoh's dream to mean seven years of plenty in Egypt to be followed by seven years of famine. The Pharaoh made him vizier of Egypt and during the seven years of plenty Joseph stored, for the Pharaoh, much grain. After the seven years of famine had gotten under way the Egyptians who had not been forewarned soon ran out of grain.

Genesis, 47:

13. And there was no bread in all the land; for the famine was very sore, so that the land of Egypt and all the land of Canaan fainted by reason of the famine.

14. And Joseph gathered up all the money that was found in the land of Egypt, and in the land of Canaan, for the corn which they bought; and Joseph brought the money into Pharaoh's house.

15. And when money failed in the land of Egypt, and in the land of Canaan, all the Egyptians came unto Joseph, and said, Give us bread; for why should we die in thy presence? For the money faileth.

16. And Joseph said, Give your cattle; and I will give you for your cattle, if money fail.

17. And they brought their cattle unto Joseph; and Joseph gave them bread in exchange for horses, and for the flocks, and for the cattle of the herds, and for the asses and he fed them with bread for all their cattle for that year.

18. When that year was ended, they came unto him the second year, and said unto him, we will not hide it from my lord, how that our money is spent; my Lord also hath our herds of cattle; there is not ought left in the sight of my Lord, but our bodies, and our lands.

19. Wherefore shall we die before thine eyes, both

we and our land? buy us and our land for bread, and we and our land will be servants unto Pharaoh; and give us seed that we may live, and not die, that the land be not desolate.

20. And Joseph bought all the land of Egypt for Pharaoh; for the Egyptians sold every man his field, because the famine prevailed over them; so the land became Pharaoh's.

21. And as for the people, he removed them to cities from one end of the borders of Egypt even to the other end thereof.

22. Only the land of the priests bought he not; for the priests had a portion assigned them of Pharaoh, and did eat their portion which Pharaoh gave them, wherefore they sold not their lands.

23. Then Joseph said unto the people, Behold, I have bought you this day and your land for Pharaoh; lo, here is seed for you, and ye shall sow the land.

24. And it shall come to pass in the increase, that ye shall give the fifth part unto Pharaoh, and four parts shall be your own, for seed of the field, and for your food and for them of your households, and for food for your little ones.

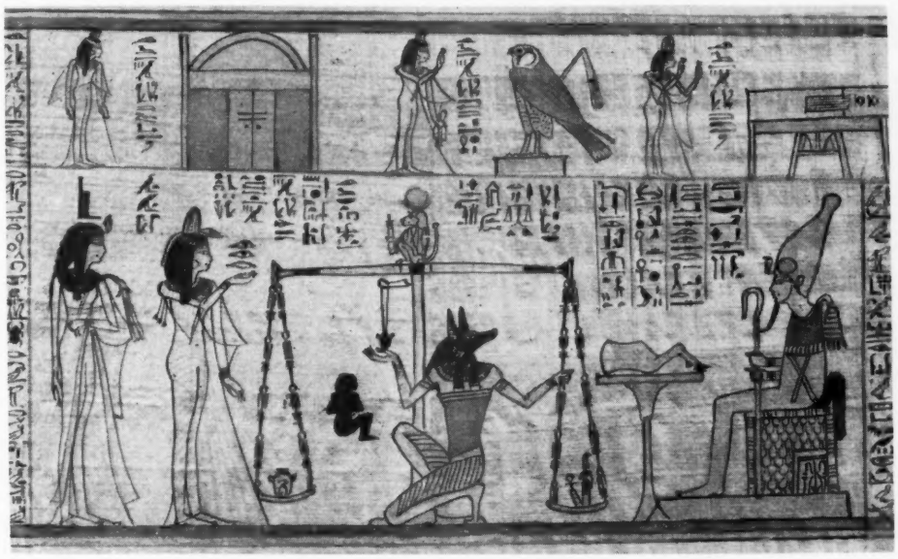


Fig. 7. Funerary Papyrus of the Princess Entiu-ny.

This section from "the Book of the Dead" shows Princess Entiu-ny standing before the Osiris, judge of souls and god of the deceased. In the center the dog-headed Anubis weights the princess's heart against the figure of the goddess of truth. To the far left stands Isis, sister of Osiris. *(Photograph obtained from the Metropolitan Museum of Art.)*

There were several remarkable persons during this period. Queen Hatshepsut (the first great woman of history) built, among many other monuments, the magnificent temples of Der el-Bahri for her own mortuary service. Thutmose III, called the Napoleon of Egypt, spent much time and effort erasing and destroying the works of Queen Hatshepsut. On May 15, 1478 B.C. with his army he descended from the heights of Carmel and fell upon the collective armies of the rebellious nations which had joined with the Syrians and defeated them in the plain of Esdraelon before the gates of Megiddo (Battle of Armageddon).[7] This was the most important victory of the time because by it the trade routes of the Near East were captured.

One of the most remarkable of the Pharaohs was Amenhotep IV. The Egyptians had many gods, spirits, demons, sacrificial ceremonies, and "mysteries." Under the empire the Theban god Amon had come to the fore, and this priesthood established in the great temple at Karnak had acquired tremendous wealth. Amenhotep IV decided that there was only one god and that was the old sun god, Re. Thereupon he set about destroying all other gods and especially the god Amon. Amenhotep IV (meaning "Amon rests") changed his name to Ikhnaton ("spirit of Aton"). His queen was Nofretete, whose bust is seen in all respectable museums and art galleries. The king had two hymns to Aton, the only god, chiseled on the walls of tomb chapels, and Breasted has shown that certain parts of these hymns are very similar to passages in the 104th chapter of the Psalms. Following the death of Ikhnaton, the old order was re-established.

One should mention Tutenkhaton ("Living image of Aton") more popularly known as "King Tut" whose tomb, discovered November, 1922, is the only one which contained possessions which had been placed in it originally and which had not been pilfered by grave-robbers.

Under Ramesses II the empire was restored, the rebelling provinces and also Nubia were brought under the Pharaoh's yoke. The booty and slave labor from Nubia (negroes) made possible the most gigantic works of man on earth, i.e., the temple of Ramesses II. (It should be remembered that all the Pharaohs were in reality the sons of the sun god, Re.)

The decline of the empire is said to have begun c. 1000 B.C. Following 145 years of rule by the priests of Amon, Sheshonk (the Biblical Shishak) seized the throne and was responsible for the sack of Jerusalem in 930 B.C. Negro kings from Ethopia ruled Egypt from 712 to 663 B.C. The Assyrian armies drove out the latter, and later Nebuchadnezzar of Babylon took the provinces of Syria and Palestine. In 525 B.C. King Cambyses made Egypt a Persian province, and Alexander the Great drove out the Persians in 332 B.C. After Alexander died (323 B.C.), one of his generals, Ptolemy, was given control and his descendants ruled Egypt for 300 years; the last of this line was Cleopatra VI (the most well-known Egyptian). The Romans ruled Egypt for 500 years and then the Moslems conquered it.

Herodotus visited Egypt sometime in the 4th century B.C. He wrote:

"For three successive days in each month they purge, hunting after health with emetics and clysters, and they think that all diseases which exist are produced in men by the food on which they live; for the Egyptians are from other causes also the most healthy of all men next after the Libyans. . . . The manner of divination however is not established among them according to the same pattern everywhere, but is different in different places. *The art of medicine among them is distributed thus: each physician is a physician of one disease and no more; and the whole country is full of physicians, for some profess themselves to be physicians of the eyes, others of the head, others of the teeth, others of the affections of the stomach, and others of the more obscure ailments.*"

When Amenhotep III fell ill (he died c. 1375 B.C.), King Tushratta of Mitanni sent the "figure of the goddess Ishtar of Nineveh, which had traveled to Egypt on a previous occasion," in order that it might restore the Pharaoh to health.[14]

Finally, a passage from Herodotus for those interested in the fee schedule of those days:

"Not long after this it happened that Darius, (King of Persia, 521-485 B.C.) while hunting, twisted his foot in dismounting from his horse, so violently that the ball of the ankle joint was dislocated from its socket. Darius called in the first physicians of Egypt, whom he had till now kept near his person, who, by their forcible wrenching of the foot, did but make the hurt worse; and for seven days and nights the king could get no sleep for pain. On the eighth day he was in very evil case; then someone, who had heard in Sardes of the skill of Democedes of Croton, told the king of him. Darius bade Democedes be brought to him without delay. Finding the physician somewhere all unregarded and forgotten among Orvetes' slaves, they brought him into view, dragging his chains and clad in rags. . . . Democedes applied Greek remedies and used gentleness instead of the Egyptians violence; . . . Darius, pleased by his wit, sent him to the king's wives. The enuchs brought him to the women, saying, this is he who saved the king's life, whereupon each of them took a vessel and scooping with it from a chest full of gold, so richly rewarded the physician that a slave named Sciton, who followed him, and picked up the staters which fell from the saucers, gathered together a great heap of gold. . . . He dwelt there in a large house, and feasted daily at the King's table, nor did he lack anything that his heart desired, excepting liberty to return to his country. By interceding for them with Darius, he saved the lives of the Egyptian physicians who had had the care of the king before he came when they were about to be impaled, because they had been surpassed by a Greek."

Egyptian Love Song

The love of my sister (sweetheart) is beyond the river;
The arm of the Nile is between us, and a crocodile lurketh on the bank.
Yet will I plunge into the depths of the water: I will walk on the flood:
My courage is high on the stream; the water is earth to my feet.
'Tis her love that maketh me mighty: that is my magic which smitheth the crocodile.
I behold now my sister cometh, and my heart is in gladness.
Mine arms open wide to embrace her: my heart exulteth within me: for my lady hath come to me . . .
She kisseth me, she openeth her lips to me: then am I joyful even without beer . . .
Oh that I were but her Nubian slave girl, her companion:
Then might I behold the fairness of her limbs!
Would that I might be my sister's launderer, if for but a single month:
Then could I wash the sweet oil from her headcloth . . .
A labor of love would it be: that would I do without pay![14]

(Continued on Page 1459)

Obstetrical Management of the Primigravid Woman

By Isadore Dyer, B.S., M.D., F.A.C.S.
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BY DEFINITION, the primigravid woman is one who is experiencing pregnancy for the first time. She is the true "mother-to-be" and, because of this fact, belongs in a special category of thought.

Untried, the obstetrician cannot draw experience or counsel from a history of her past obstetrical performances. By mere absence of this experience, her anticipation may produce anxiety and fear. Her emotions are mixed and, if not appreciated, may in themselves become a hindrance.

She must be evaluated even more carefully than the multigravid woman who has proven herself. The obstetrician is charged with the responsibility of striving for that ideal result which will be a happy, satisfactory one, ever keeping in mind that this first obstetrical experience can well interfere with her future well-being, to say nothing of her outlook for future pregnancies. Her infant risks injury and, if severe enough, may impose a cross to bear early in what could have been a happy, carefree marital career.

With these thoughts in mind, the physician who accepts a primigravida for care should constantly be aware of his responsibility and conscious of the challenge she offers.

Prenatal care is well established in the regimen of today. There are a few extra facets of prenatal care *especially* designed for the primigravid woman. A good obstetric history should be obtained, with emphasis on those previous diseases or injuries which may alter the course of this first pregnancy and delivery. An example would be such simple notations of known previous cardiovascular, renal or skeletal diseases, and their evaluation. Has she received a transfusion in the past? What surgical procedures have been performed? Is there a history of anemia, any chronic diseases or mental disease?

The family history should not be overlooked. So often the history of multiple pregnancies, large or small babies, and abnormal infants born in a family recur in subsequent generations. Likewise, diabetes, polycystic renal disease and a host of other hereditary diseases may also appear in subsequent generations.

As in history taking, one must keep in mind that it is the rule that the present pregnancy has occasioned her visit to a physician for the first time since this woman left the domain of pediatric care. She probably has never had a pelvic examination. One then cannot be too careful in bringing her physical status up to date, as it were.

The physical examination should be thorough, from head to foot, and not limited solely to the uterus and birth canal. Particular emphasis should be placed on the pelvic survey, excluding measurements or evaluation for pelvic capacity. The latter can more satisfactorily be performed later in pregnancy, preferably at the seventh to eighth month, when considerable relaxation of pelvic structures is present. Early in pregnancy, it is more important to learn of intragenital or extragenital tumors, or variations from normal in the uterus, cervix and vagina. Ovarian tumors (notoriously dermoid cysts) are frequently discovered during pregnancy, the *first* pregnancy, only because it occasioned also the first pelvic examination. The same is often true for the occasional finding of a double uterus, cervix or vagina.

When any pelvic tumor is discovered, immediate investigation should be conducted to determine its nature. Of absolute necessity is the routine performance of kidney, ureter and bladder visualization studies. In our experiences in New Orleans, anomalies of the urogenital system are considered one of the most common. An occasional pelvic kidney may be discovered encroaching on the sacrum and shortening the anterior-posterior diameter of the pelvic inlet. A dilated double kidney pelvis has been known to have been palpated in the pelvis and initially diagnosed as an ovarian cyst.

Ovarian cysts may grow during pregnancy, may twist and degenerate or commonly fall into the posterior cul-de-sac and obstruct the vaginal canal. If these growths are discovered early, we have had repeated success in removing them at eighteen weeks of gestation—with no interference with the

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pregnancy. Dermoid cysts are often bilateral, therefore both ovaries should be examined and even in those few experiences when *both* ovaries have had to be removed, the pregnancies continued to term! Recently, a 14-centimeter, simple ovarian cyst was removed from the cul-de-sac of a woman in her thirty-eighth week of pregnancy. The abdomen was closed, and she delivered successfully seventy-two hours later without incident. It must be emphasized that genitourinary studies are of extreme importance in the clinical investigation of any pelvic mass, found for the first time.

Vaginal septae should be removed prior to delivery, since serious vaginal tears have been observed to occur during descent of the fetal head. A double uterus increases the incidence of an abortion, a premature delivery or even uterine rupture. Other uterine anatomical variations may produce breech and compound presentations and even prolonged labor. Many of these observations are suspected in the early period of pregnancy and on the first pelvic examination hence the obstetrician, if observant, becomes the discoverer.

The usual laboratory investigations should be performed, including a blood and chest survey. The Rh factor must be determined since Rh-negative primigravidae *have* given birth to erythroblastotic infants even though their original sensitization was unknown to them.

No, the primigravid woman knows nothing of what the future holds for her. Most girls, as they grow up, have a certain curiosity regarding childbirth, but it remains for the presence of the actual pregnancy for the true searching curiosity to develop. Her sources of information in this respect are too often poor and inaccurate, enveloped with the fog of superstition. The average woman (including her own mother) takes great pains to exaggerate details of childbirth. It is almost as though women refuse to admit that childbearing is anything but an achievement over the most trying of all human endeavors. The primigravida becomes an object of confusion, and many will establish apprehension beyond the realm of truth.

It is clearly recognized that emotions do affect the progress of labor. It is too late if conditioning is left to the last minute. Women who are apprehensive and fearful protract their labor mechanism.

We are all aware of the relative recent fad of "natural childbirth," "childbirth without fear," et cetera. Its true value, no doubt, lies in the prepuerperal instruction and knowledge of the progress of labor in its entirety. I rather doubt that the various squatting techniques do more than emphasize knowledge of the labor process. Relaxation is a form of self-discipline, and self-discipline over one's emotions is the foundation for good human behavior in conditions of stress and strain. But let us not omit the importance of the physician-patient relationship which may reach its zenith in childbirth.

None of this approach is new. It has only been revamped for the twentieth century woman by opportunists and none too often overemphasized by various decadent groups searching for new life to put stress on their importance. For proof of the ageless observation, here is presented a quotation from "Aristotle's Compleat and Experienc'd Midwife," published in London in the year of 1700 (Page 73):

> "Others protract the birth by reason of their timidity and extreme fear of some farther pain than what she at present feels; such must be advised that it is the will of the Author of our beings that it should be so; and that others have gone through greater pains than she is like to have: Such comfortable words being oft-times a great support to the labouring woman. If she be melancholy, (for sometimes difficult labour arises from thence) endeavor by all means to make her cheerful; and encourage her to believe, that all will soon be over, and that she shall have such a child as she desires; that her sorrows will be soon turn'd into joy, and that she is in no danger—."

Five years ago, my associates and I established a program for patient instruction. This was considered a need when it suddenly became obvious to us that the Charity Hospital expectant mothers, for the most part, were better informed than our women of the higher social class. The former had the opportunity of chatting at length with medical students. Only the most inquisitive of our group received detailed information which presented a time-consuming office duty.

Three simple sessions were established, and attendance of both prospective father and mother was urged. The material we present them is outlined in Tables I, II, and III. The first two classes are given by obstetricians and the last conducted by one of the supervisors of the newborn nursery. The slide material used was procured from the Cleveland Health Museum, consisting of Kodachrome slides of the Dickinson models. McLaurin's report[1] of this endeavor follows:

TABLE I. CLASS I: THE CHANGES OCCURRING WITH PREGNANCY

1. Diagnosis of Pregnancy
   (a) Reliance on menstrual history
   (b) Symptoms of pregnancy
   (c) Biologic tests
      (1) Value
      (2) Indication for use
   (d) Fetal movements
   (e) Appearance of fetal heart tones
2. Hygiene of Pregnancy
   (a) Proper diet
   (b) Proper attitude
   (c) Importance of weight control
   (d) Superstitions
3. Laboratory Work
   (a) Nature of tests
      (1) Blood studies
      (2) Urinalyses
      (3) X-rays
   (b) Indications for tests
4. Fetal Growth during Pregnancy
5. Slides

TABLE II. CLASS II: LABOR AND DELIVERY

1. Labor
   (a) Onset
   (b) Duration or length of labor
   (c) Possibility of early rupture of membranes
   (d) How to recognize labor
   (e) Symptoms indicating need to consult physician
   (f) When to go to the hospital
2. What happens in the hospital
   (a) Mechanics of entering
   (b) Preparation by nurses
   (c) When the patient will be separated from her family
3. Delivery
   (a) Analgesia and anesthesia
   (b) Normal delivery
   (c) Use of forceps and episiotomy
   (d) Variations from normal
      (1) Breech
      (2) Cesarean section
4. Appearance of newborn
   (a) Conditions under which it will first be seen by family
5. Slides

TABLE III. CLASS III: THE BABY

1. Hospital Care of Infant
   (a) Routine nursery care—especially immediate care
   (b) Visiting—When baby may be seen by family
   (c) Identification safeguards
2. Infant feeding
   (a) Breast
   (b) Artificial
3. Care of Newborn at Home
   (a) Behavior of normal infant
   (b) The bath
   (c) The cord
   (d) Bottles
   (e) Diapers
4. Movie on preparation of formula*

*Furnished by Carnation Milk Company.

TABLE IV. CONTRACTED PELVES

	Inlet	Midplane	Outlet	Outlet Alone
Contraction	32	197	17	0
In combination	11	28	17	0

"After having had this plan in effect for the past four years, one might ask has it proved worthwhile? Also, how has it affected the course of pregnancy and labor in the patients who have taken advantage of the program?

We feel that these patients, as a group, are better behaved. Certainly, there is more rapport both with them and their families. Although there is no statistical proof available at this time, we are convinced that labors of well-oriented patients are more effective. Although sedation is not denied, the actual need for or demand for sedation is reduced. The average patient in this group receives 75 or possibly 100 mgm. of demerol per labor and many are maintained comfortably on only 50 mgm.

Remarks are frequently made by the birth room personnel concerning how well behaved and easily managed these women are. Prolonged labors are a rarity. They maintain a wholesome attitude in the postpartum period. One is rarely annoyed with a troublesome family, and the majority have expressed their appreciation for the education. They know what to expect and, for example, are not too alarmed at such a simple but frequently disturbing occurrence as molding of the baby's head.

It is suspected that in addition, these women have a more normal acceptance of their babies with less apprehension but it is too early to present statistical proof."

There is no doubt in my mind that this relatively simple approach prepares the primigravida psychologically for childbirth and has proven of value in obstetric management.

We have no statistical proof, but it is an opinion that early abortion occurs more frequently in the first pregnancy. Etiology may rest in some, in reduced thyroid activity attested by too frequent correction or avoidance of abortion when thyroid therapy is instituted prior to conception and continued until the twenty-eighth week of gestation. Persistent uterine retro-displacements share some blame and should be corrected by the third month if still present.

Toxemias of pregnancy, on the other hand, do exist more commonly in the primigravidae. This knowledge should be borne in mind throughout the prenatal period.

Evaluation of the fetal size and capacity of the pelvis for delivery is a real challenge in a first labor. The pelvis should be examined carefully during the eighth month. Clinically, the anterior-posterior diameter of the inlet, the configuration of the sacrum, the pubic arch and prominence of ischial spines can quickly and efficiently be surveyed in the office. Actual measurements of the anterior-posterior, transverse and posterior sagittal diameters of the outlet can be ascertained very simply on any examing table. An ordinary pelvimeter is the only instrument needed. These measurements are as accurate as x-ray determinations, and since the outlet mirrors the midplane architecture, valuable information is thus obtained.

In a study of 1,000 pelvic x-ray measurements,[2] we were unable to find one so-called funnel pelvis. In this study, there were 197 who revealed midplane contraction and seventeen in whom the outlet was contracted (Table IV). However, in *all* outlet contractions found, each was accompanied

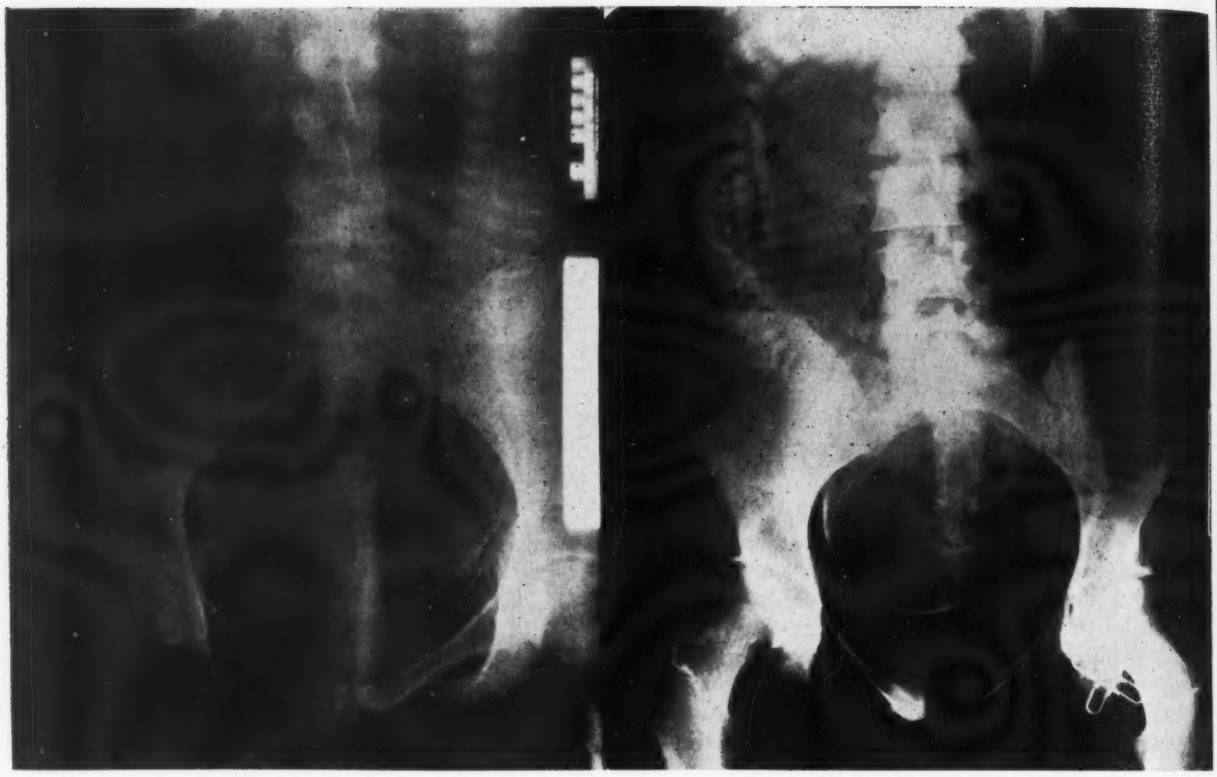


Fig. 1. Mrs. M.

	AP.	Tr.	Post. Sag.
Inlet.	13.5	14.2	6.5
Midplane	14.0	12.0*	5.2
Outlet.	14.0	12.2	10.0

*Volume, 910 cc. Fetal head, 810 cc.

Fig. 2. Mrs. O.

	AP.	Tr.	Post. Sag.
Inlet.	12.2	12.5	5.2
Midplane	11.4	9.7*	4.2
Outlet.	11.4	9.5	7.0

*Volume, 480 cc. Fetal head, 680 cc.

by midplane contraction as well. Borderline or questionable clinical findings should be further evaluated by x-ray pelvimetry.

One should always be alerted when a primigravida approaches term and the fetal head fails to enter the pelvis. In all breech presentations, x-ray investigation is indicated not only for the importance of determining fetal attitude but also to obtain estimation of pelvic capacity.

It would be well, at this point, to sum up the present evaluation of x-ray pelvimetry. All accepted techniques have proved to be accurate in their results, providing meticulous application to the method is utilized. Investigators have shown impressive figures of similar values when the *same* women were evaluated by as many as five different techniques. There are pitfalls however if the application of x-ray pelvimetry to clinical use is haphazard. For example, one cannot predict the clinical behavior of labor in a given patient with a measured pelvis, even if the capacity of the fetal skull is accurately appraised. I would like to present three interesting examples:

1. Figure 1 shows a roentgenogram of one of the largest pelves we have observed. Large in all diameters, the midplane transverse diameter was 12 cm., representing a volume of 910 cubic centimeters. The fetal head was estimated to be 810 cubic centimeters. These reports agreed with the clinical impressions. This patient failed in labor due to a poor mechanism, hindered by obesity, toxemia and thorough emotional instability. A 10-pound, 12-ounce infant was delivered by cesarean section after the membranes had been ruptured for eighteen hours with labor and non-engagement of the fetal head.

2. Figure 2 shows a pelvis asymmetric at the inlet and narrowed transversely at the midplane to 9.7 cm (volume of 480 cc.). The miplane anterior-posterior diameter was 11.4 cms. and the fetal head was estimated at 680 ccs. A trial of labor was planned with the expectancy of some arrest at the midplane if the fetal head presented in any but the anterior-posterior axis. This patient went into labor spontaneously, developed a transverse arrest at the midplane and achieved complete cervical dilatation. When rotated, the fetal head was delivered with minimal traction and without incident. The baby weighed seven pounds 2 ounces.

3. Figure 3 presents another example of midplane narrowing in a nineteen-year-old primigravida. The mid-

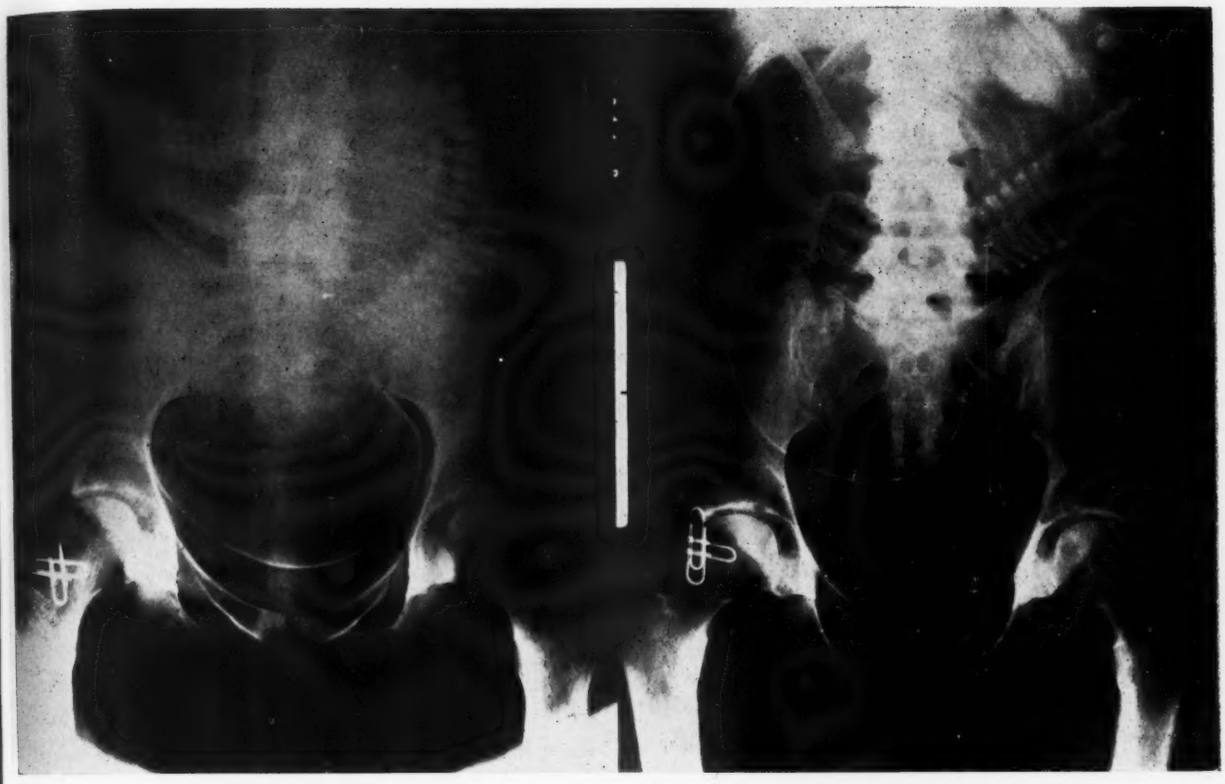


Fig. 3. Mrs. R.

	AP.	Tr.	Post. Sag.
Inlet.	11.6	12.3	4.6
Midplane	11.0	9.0*	3.3
Outlet.	11.0	10.0	7.7

*Volume, 385 cc. Fetal head, 580 cc.

plane transverse diameter was 9.0 cm (volume 385 cc.). The anterior-posterior diameter of the midplane was normal, the posterior sagittal was smaller than normal, 3.3 cm. The fetal skull was estimated at 580 cc. An excellent labor ensued which lasted twelve hours and a 6-pound, 13-ounce baby was delivered via low forceps without incident.

4. Figure IV represents a pelvis with even greater contraction. The transverse of this midplane was estimated at 8.9 cm. (volume 315 cc.). In addition, the fetal skull was larger than that in Figure 3, namely 640 cc. This unfortunate mother, the only one of this group with a previous pregnancy, had been delivered previously after a thirty-six-hour labor which was terminated with a difficult mid-forcep procedure. The child survived and is a hopeless spastic. In addition, the mother suffered major vaginal and cervical trauma. The pregnancy shown was terminated by cesarean section.

These are only a few of the many variations of human behavior coupled with pregnancy and variations in pelvic architecture.

Since pelvimetry is important chiefly to the primigravida, what values can one place on x-ray pelvimetry?

Fig. 4. Mrs. L. C. P.

	AP.	Tr.	Post. Sag.
Inlet.	13.0	11.9	4.3
Midplane	11.9	8.4*	4.0
Outlet.	11.9	10.0	8.9

*Volume, 315 cc. Fetal head, 640 cc.

TABLE V. MOLDING OF THE FETAL HEAD IN RELATIVE DEGREES OF CEPHALO PELVIC DISPROPORTION

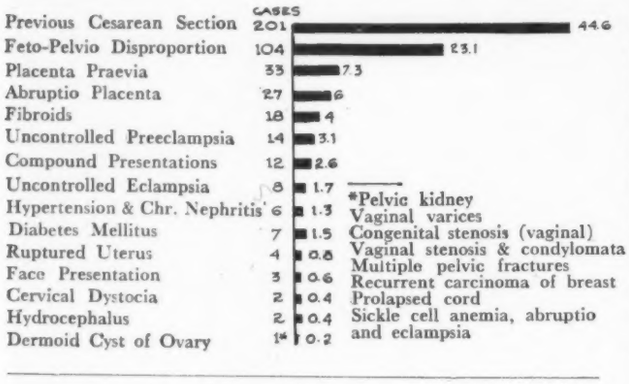
	Volume in cc.	Predicted molding
1. Normal pelvis, large baby		
Fetal head	800	
Tranverse diam, Midplane	600	25%
Disproportion	200	
2. Contracted pelvis, normal size baby		
Fetal head	600	33%
Transverse diam. Midplane	400	
Disproportion	200	

As far as pure mensuration is concerned, practice has proven that it is an accurate technique. However, known pelvic capacities must never replace intelligent observation of clinical behavior. Some diameters frequently compensate for contracted opposing diameters. The poorest prognosis has been observed in those pelves with combined inlet and midplane contraction.

The disproportion between the volume of a pelvic plane and the fetal skull can be expressed. The evaluation of this knowledge will depend not on the cubic centimeter discrepancy alone but only if it pitted against the percentage of molding expected of the fetal head (Table V). For ex-

TABLE VI. TOTAL CESAREAN SECTIONS

Tulane Service—Jan. 1, 1949-Jan. 1, 1952



ample, 200 cc. discrepancy, if the baby is large, may represent only 25 per cent of the fetal skull volume, whereas 200 cc. discrepancy in a *normal* size baby through a contracted pelvis might represent 33 per cent of the fetal skull volume. In each instance, the cephalopelvic disproportion is the same; however, in the second example, it would be unwise or perhaps impossible to expect the skull to mold one-third of its total volume without injury to the infant, the mother or both.

Finally, I know of no published so-called pelvic index which is helpful in predicting the outcome of labor in a given patient, and it is unpardonable for any roentgenologist to present a report to a physician stating *his* opinion as to the feasibility of vaginal delivery except in the rare abnormally deformed pelves. The report should be one of measurement only, the interpretation of which, like any other laboratory report, should be delegated to the obstetrician himself, who alone can evaluate all the other factors involved which play such important roles in the ultimate outcome.

The primigravida faces the prospect of cesarean section more than at any other time of her procreative career. The indications for cesarean section should not only be clear-cut, but the operator who incises her uterus for the first time should consider many factors which will influence her life thenceforth.

What thoughts should enter the mind of the operator who plans a cesarean section?

The maternal risk is increased. It is a major surgical procedure made safe today by blood banks and antibiotic drugs but still shadowed by the specter of aspiration, emboli and shock. The fetal salvage is less than in deliveries from below. The primigravida faces the stigma of a uterine scar, ever subject to subsequent rupture. She must repeat the performance with each succeeding pregnancy, in spite of the occasional instance of the patient who is allowed to deliver normally following previous cesarean section. She risks loss of later babies prematurely. Her family will be limited and the risk she takes is not only repeated but also might *increase* with parity. This ofttimes produces acute marital and moral problems, including incompatibility, pregnophobia and psychoses. She ultimately faces hysterectomy and may become a castrate long before the calculated climateric period.

Cesarean section is a serious affair in the young woman, and any conscientious obstetrician will solidify the indication by sound judgment in every case.

Our observations of the present-day indications for cesarean section are seen in Table VI. There have been no significant changes in the past eight years. Indications can be very rapidly summed up in four categories. Approximately 45 per cent are repeat procedures, and 23 per cent are for cephalopelvic disproportion. Placenta previa and premature separation account for 13 per cent. The remaining 20 per cent are for less frequently occurring conditions. Thus 81 per cent of all indications are for repeat performances, disproportion or bleeding. One can assume that a good percentage of the repeat group had as a primary indication, cephalopelvic disproportion also. This commonly used term lacks definite description and fails to qualify the true condition. Since "cephalopelvic disproportion" includes various degrees of fetal and pelvic size, variations of fetal attitude or just mere suspicion, a more complete account should be popularized.

More emphasis should be placed on interpretation of initial patient-evaluation mentioned before; on pelvic evaluation, on fetal attitude and less on sentiment and/or pressure from the family. Whereas, there is a fine line to draw between ultraconservatism and dogged radicalism, emphasis belongs on good, long-term maternal and fetal results regardless of circumstances. No procedure can substitute for an intelligent trial of labor. Utilizing a trial of labor, the primigravida is given a fighting chance to prove her worth. Many will succeed to defy all predicted obstacles. If not, the

obstetrician can certainly feel secure in his responsibility to the mother whose anatomy and physiology alone have joined forces to compel her to procreate with the aid of surgery.

This discourse would be amiss if it deleted the "horrible" caste of the "elderly primigravida." With few exceptions, any woman capable of conception for the first time at the end of the average procreative period is capable of producing a baby. Her anatomical age has merely failed to accompany her chronological age. Often one hears the statement, "It is a very valuable baby." All babies are valuable. The value of a baby of a woman of forty *seems* increased because she is usually the wife of a well-established local citizen, the banker or successful business executive with affluence. All eyes are centered on her and her obstetrician.

Intelligent management rests with the same quality of care one would offer *any* pregnant woman. The type of delivery will depend on the same standards established for *any* primigravida. Her risk should not be increased appreciably over her younger sister. In our experience, the only inconstant observation is that she might suffer a slightly greater degree of loss of pelvic support, all other considerations being equal.

In conclusion, let me emphasize that obstetric management of the primigravid woman is a challenge to the obstetrician. He holds the key to her happiness and to her future. Success in any maternity should not be measured in statistics alone, but in terms of live unharmed babies, whose mothers are physically sound following their experience in childbirth and emotionally secure with their genuine desire to repeat the performance again and again.

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A PAGE FROM MEDICAL HISTORY: EGYPT

(Continued from Page 1452)

Conclusion

The Egyptians had many gods. They built great temples and had many "mysteries" and sacrificial ceremonies. So much time and labor was spent on trying to preserve the dead and trying to live forever. They did, however, make a beginning in the science of medicine, and everyone knows that there is nothing more difficult than making a beginning. From Egypt and Babylonia the hard-won experience of the ages passed across to Greece and to the Hebrews. Through these channels our present society has been made possible.

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An Obstetrical Survey in a Small Hospital

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IF PATIENTS are to continue to receive the highest possible type of medical care, no physician must ever let himself become complacent or self-satisfied with the quality of medical care he is rendering. Without doing this, nonetheless, he must occasionally compare his results with those of others, so that he may better evaluate his own accomplishments. Through proper comparison, he is better enabled to pinpoint his efforts at self-improvement on the areas most in need of strengthening.

In the field of obstetrics, as is true in many fields, any program designed to study results must soon find itself faced with the necessity of making certain statistical surveys and comparisons. If one is working in a large teaching center, it is relatively easy to find suitable standards from comparable institutions to match against one's own results. If, on the other hand, one is connected with a small general hospital, it becomes much more difficult to find suitable material for a comparative study. It is with a hope that others might be interested in making a similar survey and find these statistics of value that the following report is made.

This study covers all the deliveries performed over a ten-year period in Mercy Hospital, a non-sectarian general community hospital, located in a city of approximately 18,000 population. The period covered is from January 1, 1944, through December 31, 1953. There were 11,876 deliveries during this period. For purposes of evaluating progress, the study was divided into two five-year periods.

At the beginning of this time, the hospital had a capacity of eighty-five beds, of which twenty-three were devoted to obstetrics. There was one delivery room. In 1952, an addition was built which increased the hospital to 135 beds. At this time, the obstetrical unit was built entirely new in this addition and consisted of two delivery rooms, labor rooms, preparation and work rooms, and thirty-one beds for maternity patients.

The obstetric care was given by a staff composed of both general practitioners and those limiting their work to obstetrics and gynecology. Any physician on the general medical staff of the hospital was granted the privilege of doing normal obstetrics, if he so desired. During the period covered, a total of fifty-five physicians delivered women at this hospital. Percentagewise, 43 per cent of the deliveries were performed by general practitioners in both periods.

In the first five-year period, cesareans were done by eight different operators, only three of whom limited their practice to obstetrics and gynecology. During the second five-year period, all these procedures were done by four surgeons, all of whom limited their practices to this specialty.

In the interest of good obstetric care, consultation was required in the presence of any of the following conditions: breech in primipara, hemorrhage, toxemia, cesarean section, prolonged labor, surgical induction of labor and operative vaginal deliveries.

Figures are not available as to the exact number of these women who had had prenatal care, but the big majority had had some. In quite a few, however, there had been none, or else the amount had been considerably short of the desirable minimum. Approximatly 90 per cent of these patients were Caucasian.

There had never been any resident staff at this hospital until July, 1951, when an interne-training program was established in conjunction with the general practice program of the University of Michigan Hospital. That program has been in effect since that time.

In Table I, we have summarized the analysis of the obstetrical work at Mercy Hospital for the period mentioned. We realize that various other aspects could have been considered, but we felt that these probably were the most important.

For the first comparison, we have brought together in Table II figures from Mercy Hospital, our own state and a neighboring state. In Michigan, at present, 90 per cent of all deliveries are done in hospitals, and the Illinois figures are for hospital deliveries.[10] From this chart, it becomes apparent that our results compare favorably with the two mentioned groups.

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TABLE I. AN ANALYSIS OF OBSTETRICAL RESULTS IN MERCY HOSPITAL 1944-1953

Year	Deliveries Including Sections	Live Births	Maternal Deaths	Sections	Still Births	Premature Deaths	Infant Deaths	Neonatal Deaths including Premature Deaths
FIRST 5-YEAR PERIOD								
1944	885	874	0	25	11	5	6	11
1945	880	863	0	18	17	10	7	17
1946	1166	1148	0	44	18	17	3	20
1947	1427	1403	2	39	24	20	6	26
1948	1324	1308	2	35	16	14	4	18
5-Year Total	5682	5596	4	161	86	66	26	92
5-Year Rate			0.71	2.87	15.3	11.8	4.64	16.4
SECOND 5-YEAR PERIOD								
1949	1226	1206	1	26	20	13	6	19
1950	1214	1199	1	27	15	10	9	19
1951	1327	1308	0	24	19	19	4	23
1952	1236	1211	1	32	25	12	12	24
1953	1191	1179	1	35	12	18	5	23
5-Year Total	6194	6103	4	144	91	72	36	108
5-Year Rate			0.655	2.35	14.9	11.8	5.90	17.7
10-Year Total	11,876	11,699	8	305	177	138	62	200
10-Year Rate			0.68	2.60	15.1	11.8	5.3	17.0

Note: Maternal death, premature death, infant death, neonatal death, and stillbirth are expressed as per 1000 live births. Sections are expressed as per cent of deliveries.

TABLE II. COMPARISON OF TEN-YEAR ANALYSIS OF LIVE-BIRTH RATE, MATERNAL MORTALITY RATE, STILLBORN, PREMATURE DEATH AND CESAREAN SECTION RATES IN MERCY HOSPITAL, ILLINOIS, AND MICHIGAN

	Live Birth	Maternal Mortality	Stillborn	Premature	Cesarean Section
Mercy Hospital	11,699	0.68	15.1	11.8	2.60%
State of Illinois 196 hospitals	1,560,835	0.97	17.1		3.68%
State of Michigan	1,344,526	0.95	20.6	10.1	

The report of Mott from St. Joseph Hospital, Patterson,[9] New Jersey, presented us with an opportunity to compare the results of Mercy Hospital for a ten-year period with those of this eastern institution.

In Table III, these two sets of figures are summarized. If cesarean percentage is a criterion, it would appear that both hospitals practice a conservative type of obstetrical care. The results in the categories listed show a very close similarity in most instances.

In the interest of making further comparative studies, it was decided to study separately, three phases of the work. These were maternal mortality, cesarean sections and fetal loss.

TABLE III. COMPARISON OF TEN-YEAR RESULTS AT ST. JOSEPH AND MERCY HOSPITALS

	St. Joseph Hospital	Mercy Hospital
Total Live Births	18,814	11,699
Total Maternal Deaths	14	8
Total Maternal Mortality in percentage	.07	.068
Total Mortality Vaginal Deliveries	.05%	.035%
Cesarean Section	1.7%	2.6%
Total Cesarean Sections	338	305
Total Mortality Cesarean Section	1.1%	1.2%

TABLE IV. COMPARISON OF MATERNAL MORTALITY IN FOUR HOSPITALS

Hospital	Total Deliveries	Maternal Mortality	Mortality Per cent
St. Anne's 1943-1947	12,209	11	.09
Huntington Memorial 1943-1947	8,014	6	.075
St. Joseph 1944-1948	9,242	7	.075
Mercy 1944-1948	5,596	4	.071

Maternal Mortality

The first review of maternal mortality was made in New York State in 1930, when it became apparent that little progress had been made in this regard between the years 1915 and 1930. At this time, the rate was six to eight deaths per thousand live births. Since then, much emphasis has been placed on this subject, and today many states make detailed studies of all such deaths.

Comparative ten-year statistics were difficult to find, but in Table IV,[9,1,4] a comparison is made

between five-year periods at four hospitals. A fairly uniform rate is found to exist. These maternal mortality rates are much improved over those of the early thirties and are lower than those which, at one time, were considered irreducible minimums. Figures from Connecticut and Oregon,[6] where in 1951 the maternal mortality rate was reduced to 0.01 per cent, prove that we cannot rest on the oars, but rather must work even harder to reach this same goal or possibly improve on it. Progress after this much improvement becomes increasingly harder and calls for redoubled efforts.

A résumé of the eight maternal deaths in this series follows:

Case 1.—This patient twenty-two years old, gravida II, para I, whose last menstrual period was November, 1946, had a normal prenatal course until the day of admission. Pregnancy was then estimated at about thirty-two weeks.

On admission in the evening of June 25, 1947, she stated that her bag of water ruptured at 1:00 p.m., and at 6:00 p.m. she began having vaginal bleeding, with blood coming in gushes. At 8:00 p.m., she began having labor pains. In spite of this, she did not enter the hospital until 11:30 p.m. After admission, the patient continued to have bleeding. A sterile vaginal examination revealed a portion of placenta in the cervical os. Fetal heart tones were not present and Braxton Hicks version was done, one foot delivered and traction applied. The body was delivered after thirty minutes, and the cervix clamped around the head. Because of poor uterine contractions and continued bleeding around the head, Duhrssen's incisions were made, and delivery of a stillborn infant was completed at 1:40 a.m. The uterus was explored and, no damage being found, was packed and the cervical incisions were closed. Normal saline was given intravenously while waiting for blood to be cross-matched. In spite of the pack plus ergotrate intravenously and intramuscularly, the bleeding continued, and it was felt necessary to explore the uterus, but, again nothing was found and the uterus was repacked. Shock had developed at this time. The patient was transferred to her room, and an attempt was made to start blood by a cut-down, but the shock state deepened, and the patient expired at 4:55 a.m.

Clinical diagnosis was (1) pregnancy at term; (2) stillborn infant; (3) premature separation of placenta; (4) shock due to hemorrhage.

Case 2.—The patient, twenty-five years old, gravida III, para II, was admitted to Mercy Hospital in active labor at term. She had a normal prenatal course until the third trimester, when she began developing a polyhydramnion. During the last two weeks prior to admission, she had not felt fetal movements and at this time the fetal heart could not be detected. In the third trimester, she was treated with sulfa drug for cystitis. Except for a gravid abdomen, physical examination findings were negative. Kahn test was negative. After four hours of labor, she delivered with ease by left occipito anterior to occipito anterior mechanism over a left mediolateral episiotomy, a macerated infant. There was an excessive amount of amniotic fluid. The placenta was delivered by simple expression with 200 cc. blood loss in third stage. Placenta was considered to be complete. Immediately following the third stage, the patient developed profound shock. Intravenous fluids were started, but the patient dislodged the needle two or three times, and finally a cut-down was done. During this time, she continued to bleed from the uterus. Ergotrate intravenously failed to contract the uterus. Oxygen was started. A consultant examined the patient and removed fragments of placenta from the poorly contracted uterus. The uterus was packed and pitocin given intramuscularly and intravenously, followed by calcium gluconate. Pack was removed after several hours. The uterine bleeding never completely stopped and in spite of blood and fluids intravenously plus adrenalin and eschatin, the shock state did not improve, and the patient expired approximately sixteen hours after delivery.

Clinical diagnosis was: (1) pregnancy at term; (2) macerated term fetus; (3) postpartum hemorrhage; (4) polyhydramnion; (5) atony of uterus.

Case 3.—This patient, twenty-five years old, gravida II, para I, whose expected date of confinement was May 9, 1948, was admitted on April 26, 1948. Except for severe vomiting during the first trimester, her pregnancy was uneventful. Because of a large retroperitoneal tumor involving pelvis, thigh, abdominal wall and labia, she had had a previous cesarean section. Physical examination was negative except for gravid abdomen and tumor mass involving the right thigh, labia, abdominal wall and retroperitoneal area in the pelvis.

Because of previous cesarean section, the patient was delivered by repeat section of a viable female infant. The postoperative course was unremarkable until the afternoon of the first postoperative day when, suddenly, while laughing and talking, she began gasping for breath and became cyanotic. She gave the impression of having severe pain, although she was comatose. Oxygen was started and coramine given without effect, and she expired twenty-five minutes later.

Clinical diagnosis was: (1) pregnancy at term; (2) postcesarean section; (3) viable female infant; (4) pulmonary embolism; (5) retroperitoneal tumor (type undertermined).

Case 4.—This patient, twenty-six years old, white, married, gravida I, para O, was admitted in active labor at term following an unremarkable prenatal course. Physical examination was not remarkable.

After a twenty-hour period of labor, a normal male infant was delivered spontaneously by left occipito anterior to occipito anterior mechanism over a left mediolateral episiotomy. During labor, blood pressure was 130/82. After saddle anesthesia and just prior to delivery, the patient complained of headache and blood pressure was 200/130. Blood pressure dropped to 170/100 immediately after delivery, and the patient was

talking and acting normally. Shortly afterwards, she began tossing in bed and talking irrationally. Two hours later, she was apparently asleep and breathing regularly and quietly. At 7:00 a.m., six hours postpartum, respirations became irregular, pulse very rapid, right pupil enlarged, neck stiff, with spastic right extremities. A spinal tap revealed pressure of 250 mm. xanthochromic fluid with 295 white blood count (70 per cent polymorphonuclears), 4 plus Pandy test with elevations of protein and sugar. Urinalysis showed 3 plus albumin and granular casts. At this time, temperature was 105° and penicillin was started. The following day, June 16, 1950, ventriculograms were done. There was normal pressure and clear fluid on the right side and increased pressure and xanthochromic fluid on the left side. X-rays suggested a mass in the third ventricle. Several hours after ventriculograms, the temperature went to 108°, the patient became cyanotic and pulse and respirations became irregular. Later the same day, she began to have convulsive movements and blood pressure became difficult to obtain. A catheter was put into the left ventricle, and there was normal ventricle pressure. The patient expired quietly at 10:25 a.m. on June 17, 1950. Autopsy was done.

Clinical diagnosis was: (1) pregnancy at term; (2) viable male infant; (3) subarachnoid hemorrhage; (4) possible colloid cyst of third ventricle.

Pathological diagnosis was: (1) hemorrhage from choroid plexus into left lateral, third ventricle and aqueduct of Sylvius; (2) edema and congestion central nervous system; (3) pulmonary congestion, edema, early bronchopneumonia; (4) acute hyperplastic splenitis; (5) parenchymatous degeneration of liver, kidney and heart; (6) pepto-esophagitis.

Case 5.—This patient, twenty-nine years old, white, primigravida, whose expected date of confinement was February 17, 1952, was admitted to Mercy Hospital on January 5, 1952 because of a large amount of painless vaginal bleeding. She had had two previous admissions in December, 1951, because of painless vaginal bleeding.

Physical examination was negative except for gravid abdomen. Hemoglobin was 9.3 gm. (58 per cent). Urinalysis showed 1 plus albumen.

On the second hospital day, this patient was transfused with 500 cc. of whole blood. She continued to have a small amount of vaginal spotting. The third hospital day, her hemoglobin was 10.9 gm. (68.1 per cent) and because of age, primiparity, x-ray evidence of pelvic asymmetry and marginal placenta previa, a cesarean section was carried out with delivery of a viable female infant.

The patient was returned to her room in good condition following the section. Five hundred cc. of whole blood was added to intravenous fluid that was started in the operating room. Three hours postoperatively a small amount of blood was noted on the abdominal dressing and there was vaginal bleeding in excess of what would be expected, but not in a large amount. Blood pressure was 105/75. Without additional signs or symptoms, in about one hour, blood pressure and pulse suddenly became unobtainable and attempt at starting transfusion was unsuccessful. Ergotrate gr. 1/320 and eschatin 2 cc. were given intramuscularly without effect, and the patient went steadily into more profound shock and expired. Autopsy was done.

Clinical diagnosis was: (1) primipara at eight months' gestation; (2) placenta previa; (3) postcesarean section with viable infant; (4) profound sudden shock.

Postmortem diagnosis was: (1) lower nephron nephrosis recent, due to incompatible blood transfusion; (2) hemorrhage into left broad ligament and retroperitoneal space and peritoneal cavity, secondary to cesarean section; (3) status following recent section; (4) Bronchopneumonia left lower lobe; (5) patchy adrenal hemorrhage recent; (6) chronic pyelitis and cystitis.

Case 6.—This patient, twenty-three years old, gravida II, para I, whose expected date of confinement was September 21, 1953, was admitted in active labor on September 21. Prenatal course was normal. Past obstetrical history was unremarkable, an 8 pound male infant having been delivered by low forceps after eight hours' labor in 1952.

Physical examination showed a normal woman with large firm gravid uterus. After thirteen hours of hard labor, x-ray pelvimetry showed a large single fetus in left occipito posterior position with floating head and an adequate pelvis. The first stage of labor was twenty-two hours, and when the cervix was fully dilated, the presenting part was at station minus one.

Two hours after the cervix was fully dilated and effaced and the presenting part at plus 1 to plus 2, it was decided to undertake delivery. The head was rotated with considerable difficulty from left occipito posterior to left occipito anterior. At this time, a large amount of bloody fluid, estimated at 1500 cc., began to gush from the uterus. Mid-forceps were applied and with difficulty a 12 pound 6 ounce female stillborn infant was delivered over a left mediolateral episiotomy.

Intravenous glucose was started immediately, and ten minutes postpartum the patient was cyanotic, blood pressure 70/30 and pulse 96 and weak. There was very little uterine bleeding after the baby was delivered, although the uterus did not contract well. Twenty minutes after intravenous injection and oxygen were started, the pulse was slow and faint and the patient was warm and dry. She did not respond, and thirty-eight minutes postpartum, she expired. Autopsy was refused.

Clinical diagnosis was: (1) amniotic fluid infusion with defibrinization; (2) term pregnancy; (3) stillborn; (4) afibrinogenemia (confirmed by blood studies).

Case 7.—This patient, twenty-six years old, white, gravida I, para O, whose expected date of confinement was February 9, 1948, was admitted February 19, 1948, after a normal prenatal course.

On admission, she was having abdominal pains, but these gradually ceased and she was discharged on March 2, 1948. She returned on March 3, having irregular pains, and was given small doses of pitocin with im-

provement in the frequency and character of contractions. The following day, contractions became irregular, and the cervix was only 2 cm. dilated, which was the same as on previous days.

Because the patient had been a sterility problem, had mild chronic hypertension and showed no progress in labor, a cesarean section was carried out with delivery of a viable female infant. During the operation, the patient suddenly became depressed, with slow shallow respirations, and the blood pressure became unobtainable. There was no evidence of bleeding, body was warm and dry, pulse was slow but weak.

Blood 350 cc., plasma 500 cc. and stimulants gave slight temporary improvement in her general condition. Two hours postoperatively she expired. Autopsy was refused.

Clinical diagnosis was: (1) pregnancy at term; (2) viable female infant; (3) postcesarean section; (4) cerebral anoxia.

Case 8.—This patient, twenty-seven years old, primigravidum, whose expected date of confinement was December 17, 1946, was admitted on December 23. Her prenatal course was unremarkable. Physical examination findings were negative except for gravid uterus with transverse presentation.

A cesarean section was carried out, with delivery of a normal male infant. The postpartum course was benign until the fifth postoperative day, when the patient developed abdominal distention, marked, with emeses of fecal-like material. Wangensteen suction was instituted. She showed some improvement until the ninth postoperative day when she developed a sudden peripheral vascular collapse. She was given 600 cc. of whole blood and coramine with much improvement in her general condition. A medical consultant felt that the patient had thrombophlebitis of the right leg, with pulmonary emboli and adrenal cortical hemorrhage. The tenth postoperative day, she seemed improved slightly, but on the following day she suddenly expired.

Clinical diagnosis was: (1) term pregnancy; (2) transverse presentation; (3) post cesarean section; (4) viable male infant; (5) thrombophlebitis with pulmonary emboli; (6) adrenal cortical hemorrhage.

Postmortem diagnosis was: (1) asphyxia; (2) bilateral pulmonary atelectasis and emphysema; (3) recent cesarean section; (4) localized abscess of anterior abdominal wall; (5) ileus; (6) ulcerative ileitis of embolic origin; (7) toxic nephritis.

The eight fatal cases have been reviewed more or less in detail. Several factors in connection with these cases are noteworthy. The cases were divided as to cause of death as follows: hemorrhage, two; embolism, one; choroid plexus hemorrhage, one; transfusion reaction due to incompatible blood, one, amniotic fluid infusion, one. The remaining two cases present no clear-cut cause of death; one on the operating table without adequate explanation, and another following cesarean section and with the cause of death still obscure even after postmortem examination.

TABLE V. COMPARISON OF CESAREAN SECTION FOR TEN YEARS IN THREE SMALLER HOSPITALS

Hospital	Number of Sections	Percentage of Sections	Maternal Mortality	Mortality Percentage
St. Joseph 1942-1951	338	1.7	4	1.1
Ind. General 1944-1953	307	2.1	6	1.9
Mercy 1944-1953	305	2.6	4	1.3

It is disconcerting that although the cesarean incidence in the total series of cases was only 2.6 per cent, four (50 per cent) of the deaths occurred in patients who had cesareans. The small series of cases may account for this extraordinary figure, and certainly it is much higher than the figure reported by Taylor[12] from the Pennsylvania study in which 146 of 959 maternal deaths were encountered in cesarean section. This latter figure represents 15.2 per cent. Contemplation of these figures should be a deterrent for the poorly considered cesarean section.

The two deaths from hemorrhage are dramatic and pitiful evidence of the failure to take early and aggressive action in the presence of hemorrhage. One of them, likewise, is illustrative of the comment of Dr. Miller, "Faulty judgment which leads to use of untimely operative procedures in the absence of justifiable indications . . ."[8]

The second case of death due to hemorrhage might reasonably be considered to fall in the category of defibrination due to the presence of a macerated fetus in the uterus. This can only be conjecture at this time, of course. However, in both instances frantic efforts were made to give blood after a shock state had developed, instead of making preparations for this procedure at a time when such efforts might have been more easily carried out and to much more avail.

It is disturbing to realize that even with a resident staff and with blood available in the bank, the patient in Case 6 progressed to fatal termination so rapidly that adequate therapy could not be instituted. Fibrinogen was not available at that time, even if its need had been immediately recognized.

Specific comment cannot add much to the previous presentation of the other maternal deaths. A serious language difficulty may have been a factor in the death from incompatible blood, in that,

TABLE VI. INCIDATIONS FOR 305 CESAREAN SECTIONS DONE AT MERCY HOSPITAL 1944-1953

Year	Cephalo-Pelvic Disproportion	Hemorrhage	Mal-Presentation	Toxemia	Inertia Primary and Secondary	Previous Section	Miscellaneous*
1944	7	2	0	1	3	8	4
1945	6	1	1		4	4	2
1946	13	4	5	1	4	12	5
1947	15	4	3	0	1	12	4
1948	10	3	2	0	2	18	0
1940	7	4	0	0	4	10	1
1959	7	3	2	1	1	11	2
1951	6	3	0	1	1	12	1
1952	8	9	2	0	4	9	0
1953	8	8	6	0	1	11	2
Total	87	41	21	4	25	107	21

*Pregnancy at term (1)—1944
Postmaturity and POP (1)—1944
Previous Duehrssen's incision (2)—1944
Obstructing tumor (3)—1944, 1950, 1953
Previous difficult deliveries (1)—1945
Cervical amputation and previous pelvic surgery (1)—1945
Perineorrhaphy, suspension, and previous pelvic surgery (1)—1946
Diabetes Mellitus (3)—1946, 1947, 1950
Erythroblastosis (2)—1946, 1947
Fetal distress (1)—1946
Carcinoma of cervix (1)—1946
Cardiac decompensation (1)—1947
Removal of stillborn 8½ months baby (1)—1947
Bowel obstruction (1)—1949
Prolapse cord (2)—1951, 1953

if the patient had been able to make the nature of her complaints more clearly understood, definitive action might have been taken earlier.

It is reasonable to assume that there have been an average number of convulsive toxemias during this ten-year period, although accurate figures are not available. Certainly, there is a definite incidence of non-convulsive toxemia. Dr. Miller[8] states that 20 per cent of maternal deaths are due to toxemia, a figure which is verified by Longyear, Ott and Sutton,[7] who give the figure of 19.1 per cent in Michigan in 1950. This figure is compared in their article with 28.3 per cent in Minnesota in the same year, and 25.9 per cent in Illinois in the years 1948-1951. In the light of these figures, two maternal deaths might have been expected from toxemia and the absence of any deaths from this cause is not explained. Certainly, no unusual therapy was employed in the management of patients with toxemia.

There have been no hard and fast rules established for the management of obstetric hemorrhage, except the rules requiring consultation which were formulated following the First American Congress on Obstetrics in 1939, but which were not effective for several years thereafter. These rules require consultation with a recognized consultant, for all patients who have hemorrhage. Beyond that, treatment has been individualized, and a relatively high number of patients have been delivered vaginally in the presence of abruptio placenta and partial placenta previa, with satisfactory results. Cesarean section has by no means been the immediate refuge of the consultant in cases of hemorrhage.

Cesarean Sections

Shortly before the period covered by this report, our hospital had a cesarean section rate which was above the national rate and accepted averages and resulted in criticism by the accreditation committee. With the inauguration of compulsory consultation in all such cases the rate dropped, and for this ten-year period our average falls in the group of hospitals with a relatively low incidence.

Hoffman[5] states that reported cesarean rates vary from 0.5 per cent to 14 per cent, a variation which hardly seems justifiable. Table V[5,10] summarizes the ten-year record for cesareans in three hospitals with relatively low incidence of sections.

Breaking down the figures from Mercy Hospital into two five-year periods a few trends appear. In the first period, there were three deaths in 161 sections for a mortality rate of 1.8 per cent. The three deaths were from embolism, electrolytic imbalance and one from an unknown cause. In the second period, there was one death in 144 sections for a mortality rate of 0.7 per cent. This one death was from an incompatible blood transfusion. In the first period, the operations were performed by a total of eight surgeons, five of whom were general surgeons. In the second period, the operations were done by four surgeons, none of whom was a general surgeon.

In Table VI are listed the indications for the sections. It will be seen that in the first five-year period, fifteen were done for so-called miscellaneous indications. In the second period, only six were done for these reasons.

It is noteworthy that with the gradual disappearance of the general surgeon from the cesarean

section stage, there has been a decrease in the number of cesarean sections for miscellaneous indications. While there is only slight decrease in the total incidence of cesarean sections, it is our feeling that more clear-cut diagnoses are made, that cephalopelvic disproportion has been more clearly evaluated before labor has proceeded to an inevitably tragic outcome, that the fear of section after failed forceps has been lessened, and that cesarean section may be the selected treatment in the presence of hemorrhage. These and other factors have maintained the percentage of cesarean sections at the level given, but on a more seemingly justifiable basis. The figure of 2.87 per cent in the first five years, and 2.35 per cent in the second five years, is of interest in the light of the 4.8 per cent cesarean incidence at the Chicago Lying-In Hospital as given in the Annual Report, 1953-54.[2]

Our experience and the experience of Mott[9] again reiterate the increased risk in cesarean section over that of vaginal delivery. Mott reported for ten years a mortality rate of 1.1 per cent for cesarean deliveries and 0.05 for vaginal. Our respective figures are 1.3 and 0.03.

Fetal Loss

The results of the study of fetal loss show that progress here is lagging. We were quite disappointed and surprised to find that results in the two periods were very similar. Corresponding findings have been reported by others. Hawkins[4] reported some statistics for all hospitals in the State of Illinois having 1,000 or more births per year. In these, the stillbirth rate in 1943 was 20.5 per thousand live births, and in 1947 it was 16.3. In neonatal deaths, it was 19.7 in 1943 and 22.1 in 1947. In his own hospital, the same figures were: stillbirths, 15.9 in 1943 and 18.3 in 1947; neonatal deaths, 17.6 in 1943 and 18.0 in 1947.

In Table VII the results for five-year periods in four hospitals are given.[1,4] The results are very similar. Figures from the other hospitals for later years were not available.

Our experience welds another link in the growing chain of evidence pointing to the need of the expenditure of great energy to solve the problem of prematurity. Only sixty-two full-term, live-born babies died out of 11,699 live births. This gives a percentage of one-half of one. There was a total of 667 premature deliveries with a loss of 138 for a percentage of 20.5.

TABLE VII. COMPARISON OF FETAL LOSS IN FOUR HOSPITALS

Hospital	Live Births	Stillbirths		Neonatal Deaths	
Swedish (Seattle) 1938-1947	19,736	359	1.8%	299	1.5%
Huntington Memorial 1943-1947	7,912	102	1.28%	124	1.5%
St. Anne's (Chicago) 1943-1947	12,209	215	1.7%	210	1.7%
Mercy 1944-1948	5,596	86	1.53%	92	1.6%

Dr. Edith Potter, in discussing Hawkins' paper, said that in Chicago Lying-In Hospital much progress had been made in reducing this loss. In 1931, the combined loss from stillbirth and neonatal deaths was forty-one per thousand live births. By 1948, this had been reduced to twenty-one. Although smaller hospitals will have a much harder job to get the results possible in an institution like Lying-In, nonetheless, these results are a challenge to us, and this part of our program obviously needs much careful study.

Contemplation of over-all statistics tends to cause complacency. It is only necessary to subject specific areas to critical analysis to bring about the realization of a need for improvement. Small hospitals, such as ours, are not likely to make such studies unless impetus is provided from some outside source. A distressing factor in making such a survey is the lack of complete records. This condition may very well exist in many small institutions that have adequate material for studies which might make contributions to our total knowledge. Focusing attention on our weaknesses should strengthen our determination to prevent recurrence of our mistakes.

Conclusions

From a survey of the ten-year results of an obstetric service in a general hospital in a small community, the following conclusions may be drawn:

1. Although the maternal mortality percentage compares favorably with figures from other institutions, an analysis of the individual deaths shows preventable deaths still occur and the goal of

irreducible level of maternal mortality is not yet reached.

2. The increased risk of cesarean delivery over vaginal is again demonstrated.

3. Improvement in reducing fetal loss is lagging behind that in lowering maternal loss. Coordinated co-operation between obstetrician, pediatrician and anesthetist is indicated in an attack on this problem.

4. More intensive efforts to solve the problem of prematurity are indicated.

Summary

1. Statistical studies of the obstetrical service in a small general hospital have been presented.

2. Total maternal deaths are comparable to national averages during the period studied.

3. Fifty per cent of the maternal deaths occurred in patients who had cesarean sections, representing 2.6 per cent of the total number of deliveries.

4. Fetal loss has not showed any satisfactory improvement in the ten-year period studies.

Addendum:

Since this survey was made, 1,185 additional deliveries have been cared for on this service, with no maternal deaths.

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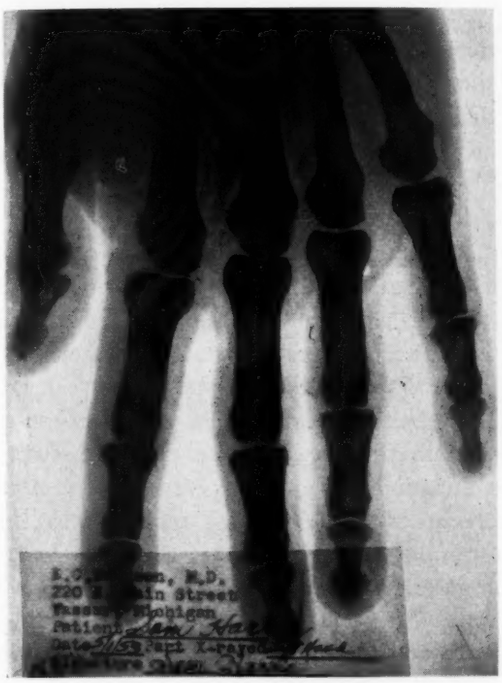
960 Agard Street (Dr. Thorup)

Identifying X-Ray Films

By E. C. Swanson, M.D.

Vassar, Michigan

A REVIEW and evaluation of the progress in the field of x-ray concerning the absolute identification of films after exposure failed to disclose any simple certain method of solving the problem. The following method, which has been utilized in the author's office for the past several years, has proved satisfactory.



The method of reproducing signatures and other pertinent data has been through the use of translucent paper which is used in industry for the copying of communications. On this paper, the following information is inscribed:

E. C. Swanson, M.D.
220 N. Main Street
Vassar, Michigan

Patient .....

Date .....Part x-rayed.....

Signature .....

This slip of paper, on which the data have been inscribed, is placed in the cassettee under the film before exposure, and the information is transferred to the film at the time of exposure.

The usefulness of this manner of imprinting the

(Continued on Page 1540)

Agranulocytosis Following Chlorpromazine Therapy

By Vladimir Prokopowycz, M.D.

Northville, Michigan

THE REPORTS about toxic, depressant action of Chlorpromazine on the bone marrow are, to date, very limited. "Animals given thorazine for ninety days by oral or parenteral routes showed no significant variations in the blood picture and no pathological changes in any tissue, organ or system."* "Extensive studies of hematopoietic activity in several large series of patients receiving thorazine revealed no deleterious effects from the drug, even after prolonged use."**

The chemical name of Chlorpromazine is 10-3-dimethylaminopropyl-2-chlorphenothiazine hydrochloride. This compound consists of two benzene rings connected with one sulfur and one nitrogen atom, with attached dimethylaminopropyl group. Shortly, it is a phenothiazine derivative.

The writer reports having a case of acute agranulocytosis with a fatal outcome which was caused, in all probability, by the use of chlorpromazine. The fulminating onset, typical clinical picture and short duration of the illness were closely observed and recorded. The clinical picture was similar to agranulocytosis, sometimes observed following administration of aminopyrine.

Case Report

A sixty-two-year-old woman was admitted to the hospital with a diagnosis of presenile brain disease, in February, 1953. The physical examination did not reveal any pathological abnormalities at the time of her admission. Laboratory findings were as follows: Urine: albumin negative; sugar negative; sediment in normal ranges. Complete blood study: red cells 5,100,000; white cells 8,400; hemoglobin 88 per cent; Kahn test negative. The chest x-ray did not reveal any abnormalities of the heart or lungs.

After admission, patient was treated symptomatically for ankle edema, constipation, seborrhea and disturbed behavior. She was given digitoxin, 0.1 milligrams daily for two months; mercuhydrine, 1 cc. intramuscularly each week for one month; phenobarbital, grain ½, three times daily for one month; chloral hydrate, 8 cc., as needed for sleep, for three months, and mineral oil, as needed. During the treatment, repeated blood and urine studies were done. These did not reveal any pathological abnormalities. Her behavior continued to be much disturbed. Chlorpromazine,† 50 milligrams three times daily, was instituted on October 14, 1954, with the simultaneous discontinuance of all other medication.

Improvement of her mental condition was striking. She sat in a chair very quietly most of the day. She was neatly dressed and tidy. She ate well and was more co-operative. The continuous grimacing and disturbed behavior disappeared. She attended movies and watched the pictures intently and quietly. Twelve days later, on October 26, 1954, Chlorpromazine was reduced to 50 milligrams twice daily because the patient seemed to be somewhat somnolent. An allergic rash appeared on the face, neck and upper back, and the patient was given Benadryl, 50 milligrams three times daily, orally, for three days, in addition to Chlorpromazine. The allergic rash disappeared. The blood study done one month after chlorpromazine therapy was begun, November 16, 1954, was as follows: red cells 4,180,000; white cells 8,050; hemoglobin 88.8 per cent. Schilling differential: myelocytes 1; segmented 68; lymphocytes 20; monocytes 11. The dose of Chlorpromazine was increased again to 50 milligrams three times daily and was continued until December 5, 1954, and there were no unusual changes in her physical or mental status.

Suddenly, approximately seven weeks after treatment with Chlorpromazine was begun, on December 5, 1954, the patient developed a high temperature (102.2° F.), great weakness, complete anorexia and profuse perspiration. Physical examination revealed a diffuse, ulcerated tonsillitis and pharyngitis. Lung and heart were clear to percussion and auscultation. Abdomen soft, nontender. Extremities were normal. Morphological blood study was done on December 6, 1954, with the following results: red cells 3,900,000; white cells 1,500; hemoglobin 75 per cent. Schilling differential: myelocytes 4; eosinophils 2; lymphocytes 70; monocytes 20. Sedimentation rate, index 32. Urinalysis: specific gravity 1.021; albumin 3+; sugar 1+; many granular casts in sediment. Nonprotein nitrogen 55.8 per cent. Later that day, the temperature went to 105° F. Blood pressure dropped to 70/35, pulse 180 per minute, breathing became rapid and superficial. Patient went into deep shock. Penicillin, 400,000 units, intramuscularly stat, streptomycin, 1 gram intramuscularly, intravenous 5 per cent glucose in water and nasal oxygen were administered. Despite all of those measures, patient died on December 7, 1954, in the morning hours. Autopsy and bone marrow studies were refused by the patient's relatives.

This report describes the clinical course in a patient receiving Chlorpromazine for disturbed behavior, who died of agranulocytosis seven weeks after the drug was begun.

Complete serial blood studies should be carried out on patients receiving this drug. Further control studies on the effects of Chlorpromazine on the hematopoietic system are desirable, particularly since the drug has been felt to be relatively nontoxic to date.

*Citation from "Questions and Answers on Thorazine," page 2, chapter 9, Smith, Kline and French Laboratories, Philadelphia.

**Citation from "Thorazine," Smith, Kline & French Laboratories, Philadelphia.

Michigan Clinical Institute

Sheraton-Cadillac Hotel, Detroit

Wednesday-Thursday-Friday, March 7-8-9, 1956

L. W. Hull, M.D., Detroit, General Chairman

Information

- **HEADQUARTERS**—Sheraton-Cadillac Hotel: Assemblies, Exhibits and Press Room on Fourth Floor.

- **REGISTER**—Top of stairs—Fifth Floor—as soon as you arrive.

Hours: Tuesday, March 6—1:00 p.m. to 5:00 p.m.

Wednesday, March 7—7:30 a.m. to 5:15 p.m.

Thursday, March 8—8:45 a.m. to 5:15 p.m.

Friday, March 9—8:45 a.m. to 3:30 p.m.

- **NO REGISTRATION FEE** for Members of MSMS and other State Medical Associations, AMA, and Canadian Medical Association.

- **ADMISSION BY BADGE ONLY** to all Assemblies, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

- **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada and physicians of the Army, Navy, and U. S. Public Health Service are invited to attend as guests. No registration fee. Please present credentials at the Registration Desk.

  Bona fide doctors of medicine who are associate or probationary members of Michigan county medical socities or who are serving as residents or interns, if vouched for by the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests, with no registration fee. Please present credentials at the Registration Desk.

- **MICHIGAN DOCTORS OF MEDICINE**, in practice but who are not members of MSMS, if listed in the American Medical Association Directory, may register as guests upon payment of $25.00. This amount will be credited to them toward dues in the Michigan State Medical Society FOR 1956 ONLY, provided they subsequently are voted into membership by the county medical society in whose jurisdiction they practice.

- **DOCTOR**, register Tuesday, to save your time! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday-Thursday-Friday, during the 1956 Michigan Clinical Institute. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.

  We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, March 6, from 1:00 to 5:00 p.m., Fifth Floor, Sheraton-Cadillac Hotel.

- **TELEPHONE SERVICE**—Local and long distance telephone service will be available in the Sheraton-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by an announcement on the screen. Call the Sheraton-Cadillac Hotel, Detroit, Woodward 1-8000, and ask for the Michigan Clinical Institute extensions on the fourth floor.

- **CHECKROOM** is available in the Sheraton-Cadillac Hotel, fourth floor, next to Grand Ballroom.

- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Arrangements. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

- **PAPERS WILL BEGIN AND END ON TIME**—Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings and panels will open on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the Program. All who attend the Institute, are respectfully requested to assist in attaining this end by noting the schedule carefully and by being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

- **TECHNICAL EXHIBITS**—Eighty-one interesting and instructive displays—will open daily at 8:45 a.m. and close at 5:15 p.m., except on Friday when the exhibit breaks up at 3:30 p.m. Frequent intermissions to view the exhibits have been arranged daily before, during and after the assemblies.

- **THE SCIENTIFIC EXHIBIT** will be located in the Reception Room, adjoining the Grand Ballroom, fourth floor, Sheraton-Cadillac Hotel.

- **THERE IS SOMETHING** of interest or education in the large exhibit of technical displays. **SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN CLINICAL INSTITUTE.**

THREE DISCUSSION CONFERENCES

These quiz periods will be held Wednesday-Thursday-Friday, March 7-8-9, Grand Ballroom, Sheraton-Cadillac Hotel, 12:00 noon to 1:00 p.m. with all the guest speakers of the day invited to appear on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss one of your interesting cases with them, is thus provided.

• **POSTGADUATE CREDITS** are given to every MSMS member who attends the Michigan Clinical Institute. Notify J. M. Sheldon, M.D., Chairman, MSMS Committee on Postgraduate Medical Education, 1313 E. Ann St., Ann Arbor, Michigan.

• **PARKING**—Do not park on Detroit's streets. Inside parking at a convenient distance from the Sheraton-Cadillac Hotel is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

• **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

• **"UBIQUITOUS HOSTS"**—The following doctors of medicine have placed themselves at the disposal of the out-of-Michigan guest essayists who grace the program of the tenth annual Michigan Clinical Institute in Detroit; they will demonstrate the meaning of Michigan hospitality to the eminent speakers from other parts of the United States: J. G. Bielawski, M.D., Detroit; E. I. Carr, M.D., Lansing; Leon DeVel, M.D., Grand Rapids; L. Fernald Foster, M.D., Bay City; W. M. LeFevre, M.D., Muskegon; G. T. McKean, M.D., Detroit; B. T. Montgomery, M.D., Sault Ste. Marie; D. W. Myers, M.D., Detroit; C. A. Payne, M.D., Grand Rapids; J. L. Posch, M.D., Detroit; W. D. Robinson, M.D., Ann Arbor; E. A. Sharp, M.D., Detroit; and L. W. Walker, M.D., Lansing.

• **PRESS RELATIONS COMMITTEE** for the 1956 Michigan Clinical Institute: C. L. Weston, M.D., Chairman, Owosso; H. F. Dibble, M.D., Detroit; A. B. Guinn, M.D., Hastings; Ralph W. Shook, M.D., Kalamazoo; and Arch Walls, M.D., Detroit.

• **L. W. HULL, M.D.**, Detroit, is General Chairman of Arrangements for the 1956 Michigan Clinical Institute.

• **MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS**

Tuesday, March 6, 1956

1. **Michigan Chapter, American College of Surgeons**—8:00 a.m. meeting; 6:30 p.m. reception; 7:30 p.m. dinner.
2. **Michigan Branch, Academy of Pediatrics**—2:00 to 5:00 p.m. clinical conference to be followed by dinner and evening program.

Wednesday March 7, 1956

3. **Michigan Regional Committee on Trauma, American College of Surgeons**—luncheon-meeting.
4. **Conference for Residents, Interns and Senior Medical Students**—2:30 p.m. meeting; 5:30 p.m. reception.
5. **Woman's Auxiliary to Michigan State Medical Society, Board Meeting**—beginning with registration at 9:30 a.m.
6. **Michigan Academy of General Practice, Board of Directors and Delegates**—6:00 p.m. dinner.
7. **Cancer Luncheon** honoring Alton Ochsner, M.D., New Orleans, La., and Owen H. Wangensteen, M.D., Minneapolis, Minn.

Thursday, March 8, 1956

8. **Operating Room Nurses Conference**—meeting all day Thursday, March 8 and on Friday, March 9.
9. **Michigan Heart Association, Board of Trustees**—dinner-meeting at 6:30 p.m.
10. **Testimonial Luncheon** honoring Presidents of National Organizations: W. H. Beierwaltes, M.D., Ann Arbor; A. C. Curtis, M.D., Ann Arbor; R. N. DeJong, M.D., Ann Arbor; A. C. Furstenberg, M.D., Ann Arbor; C. S. Livingood, M.D., Detroit; R. C. L. Markoe, M.D., Detroit; R. H. Meade, M.D., Grand Rapids; Frederic Schreiber, M.D., Detroit; F. F. Yonkman, M.D., Summit, N. J.; and W. W. Zuelzer, M.D., Detroit.
11. **Michigan Proctologic Society**—reception-dinner-meeting.

Friday, March 9, 1956

12. **Operating Room Nurses Conference**—continued from Thursday, March 8.

• **ACKNOWLEDGMENTS**—The Michigan Clinical Institute gratefully acknowledges the co-operation of

1. The Michigan Regional Committee on Trauma, American College of Surgeons, sponsor of the trauma program (six speakers) on Wednesday afternoon, March 7.
2. The Michigan Heart Association, sponsor of the heart and rheumatic fever program (six speakers) on Thursday morning, March 8.
3. The Michigan Foundation for Medical and Health Education, Inc., sponsor of Alton Ochsner, M.D., New Orleans, La., the Foundation Lecturer.
4. The Michigan Cancer Co-ordinating Committee, sponsor of Owen H. Wangensteen, M.D., Minneapolis, Minn., the MCCC Lecturer.
5. Michigan Medical Service and the Michigan State Medical Society—co-sponsors of the Conference for Residents, Interns and Senior Medical Students.
6. Davis & Geck, Inc., Danbury, Conn., for sponsorship of the color motion pictures shown during the MCI in the Normandie Room, Sheraton-Cadillac Hotel.
7. Michigan Medical Service, which contributes notepads for use of MCI registrants.

MUCH THAT IS NEW AND INTERESTING WILL BE FOUND IN THE MCI EXHIBIT

THE "BLOCK SYSTEM"
at the
1956 MICHIGAN CLINICAL INSTITUTE

Surgery—Wednesday morning, March 7
Trauma—Wednesday afternoon, March 7
Heart and Rheumatic Fever—Thursday morning, March 8
Internal Medicine—Thursday afternoon, March 8
Obstetrics and Pediatrics—Friday morning, March 9
General Practice—Friday afternoon, March 9

Michigan Clinical Institute
1956

L. W. HULL, M.D.

L. W. HULL, M.D., Detroit, is General Chairman of Arrangements for the 1956 Michigan Clinical Institute. Doctor Hull is a Past President of the Michigan State Medical Society.

Program

WEDNESDAY, MARCH 7, 1956

A.M.

7:30 REGISTRATION—Top of Stairs, Fifth Floor, Sheraton-Cadillac Hotel

8:45 EXHIBITS OPEN—Fourth Floor, Sheraton-Cadillac Hotel

FIRST ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: L. W. HULL, M.D., Detroit

Secretary: J. M. HAMMER, M.D., Parchment

8:50 WELCOME

WM. S. JONES, M.D., Menominee
President, Michigan State Medical Society

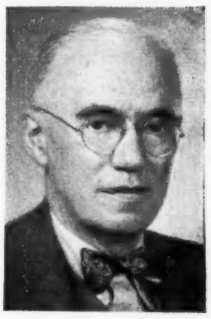
MILTON A. DARLING, M.D., Detroit
President, Wayne County Medical Society

SURGERY

9:00 "The Prevention of Death Following Cranio-cerebral Injuries Caused by Automobile Accidents."

DONALD MUNRO, M.D., Boston, Massachusetts

Associate Professor of Neurosurgery, Boston University Medical School; National Medical Advisor on "Paraplegia"—Liberty Mutual Insurance Company; Chief of Department of Neurosurgery and Rehabilitation—Massachusetts Memorial Hospitals; Formerly Surgeon in Chief for Neurosurgery and Head of the Department of Neurosurgery—Boston City Hospital.



DONALD MUNRO, M.D.

E. A. OSIUS, M.D.

9:30 "Peripheral Arterial Disease"

EUGENE A. OSIUS, M.D., Detroit

Chief, Department of Surgery and Vice Chief of Staff, Harper Hospital; Clinical Associate Professor of Surgery, Wayne University Medical School

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 THE MICHIGAN CANCER CO-ORDINATING COMMITTEE LECTURE

"Trends and Accomplishments in Alimentary Tract Cancer"

OWEN H. WANGENSTEEN, M.D., Minneapolis, Minnesota

Chief, Department of Surgery, University Hospital and Professor of Surgery

O. H. WANGENSTEEN, M.D.

ALTON OCHSNER, M.D.

W. C. BAUM, M.D.

G. J. CURRY, M.D.

M. M. FROLICH, M.D.

N. S. GIMBEL, M.D.

E. S. GURDJIAN, M.D.

M. L. MASON, M.D.

11:30 THE MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION, INC., LECTURE

"What's New in Lung Cancer"

ALTON OCHSNER, M.D., New Orleans, Louisiana
The Wm. Henderson Professor of Surgery and Chairman of the Department of Surgery, Tulane University School of Medicine; Director of Surgery, Ochsner Clinic

12:00 End of First Assembly

12:00 DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: R. L. MUSTARD, M.D., Battle Creek

Participants: WILLIAM C. BAUM, M.D., Ann Arbor; GEORGE J. CURRY, M.D., Flint; MICHAEL M. FROHLICH, M.D., Ann Arbor; NICHOLAS S. GIMBEL, M.D., Detroit; E. STEPHEN GURDJIAN, M.D., Detroit; MICHAEL L. MASON, M.D., Chicago; DONALD I. MUNRO, M.D., Boston; ALTON OCHSNER, M.D., New Orleans, La.; EUGENE A. OSIUS, M.D., Detroit; and OWEN H. WANGENSTEEN, M.D., Minneapolis, Minn.

P.M.

1:00 Lunch Hour

SECOND ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: D. A. CAMPBELL, M.D., Ann Arbor
Secretary: S. E. CHAPIN, M.D., Dearborn

TRAUMA

2:00 "Management of Bladder and Urethral Injury Following Pelvic Fracture"

WILLIAM C. BAUM, M.D., Ann Arbor
Associate Professor of Urology-Surgery, University of Michigan

2:15 "Accident Proneness"

MICHAEL M. FROHLICH, M.D., Ann Arbor
Professor of Psychiatry, University of Michigan; Director, Veterans' Readjustment Center

2:30 "Responsibility to the Injured"

GEORGE J. CURRY, M.D., Flint
Chairman National Committee on Transportation of the Injured, American College of Surgeons; Chairman Sub-Committee—Regional Committees on Trauma, U. S. and Canada; Member Board of Governors, American College of Surgeons

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "New and Old Methods of Managing Burn Wounds"

NICHOLAS S. GIMBEL, M.D., Detroit
Associate Professor of Surgery, Wayne University

4:15 "Shoulder Hand Syndrome"

E. STEPHEN GURDJIAN, M.D., Detroit
Professor of Neurological Surgery, Wayne University College of Medicine

4:30 "Injuries of the Hand"

MICHAEL L. MASON, M.D., Chicago, Illinois
Professor of Surgery, Northwestern University Medical School; Secretary, American College of Surgeons; Attending Surgeon, Passavant Memorial Hospital

5:00 **End of Second Assembly**
(No evening MCI meeting)

THURSDAY, MARCH 8, 1956

A.M.

8:45 **REGISTRATION—Top of Stairs, Fifth Floor, Sheraton-Cadillac Hotel**

EXHIBITS OPEN—Fourth Floor, Sheraton-Cadillac Hotel

THIRD ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

SEVENTH ANNUAL MICHIGAN HEART DAY

Chairman: H. L. SMITH, M.D., Detroit
Secretary: J. B. ROWE, M.D., Flint

Sponsored by Michigan Heart Association

9:00 **Michigan Heart Association Members' Meeting**

HEART AND RHEUMATIC FEVER

9:15 **"Prevention and Prophylaxis of Rheumatic Fever"**
BENEDICT F. MASSELL, M.D., Boston, Mass.
Research Director, House of the Good Samaritan; Assistant Clinical Professor of Pediatrics, Harvard Medical School

9:45 **"Interatrial Septal Defect—Its Clinical Course and Surgical Correction"**
ANTHONY C. NOLKE, M.D., Detroit
Associate Pediatrician in Chief and Associate Professor of Pediatrics, Wayne University College of Medicine
and
JAMES B. BLODGETT, M.D., Detroit
Associate Surgeon, Grace Hospital; Assistant Surgeon, Children's Hospital

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Diuretics in the Treatment of Congestive Heart Failure"**
YOSHIKAZU MORITA, M.D., Detroit
Assistant Professor of Medicine, Wayne University College of Medicine

11:20 **"Clinical Evaluation of Senthrom (G-23350)—A New Oral Anti-Coagulant"**
JOSIAH A. POLHEMUS, M.D., Ann Arbor
Junior Clinical Instructor, Department of Internal Medicine, University Hospital, Ann Arbor

11:40 **"Epidemiological Aspects of Heart Disease"**
ANCEL KEYS, M.D., Minneapolis, Minnesota
Professor in the School of Public Health and Director of the Laboratory of Physiological Hygiene, University of Minnesota

12:00 **End of Third Assembly**

12:00 **DISCUSSION CONFERENCE**
Grand Ballroom, Sheraton-Cadillac Hotel
Leader: W. B. COOKSEY, M.D., Detroit
Participants: JAMES B. BLODGETT, M.D., Detroit; ANCEL KEYS, M.D., Minneapolis, Minnesota; LEO LOEWE, M.D., Brooklyn, N. Y.; BENEDICT F. MASSELL, M.D., Boston; YOSHIKAZU MORITA, M.D., Detroit; ANTHONY C. NOLKE, M.D., Detroit; JOSIAH A. POLHEMUS, M.D., Ann Arbor; HENRY J. RICKETTS, M.D., Chicago; TOM D. SPIES, M.D., Birmingham, Alabama; and ROBERT W. WILKINS, M.D., Boston, Mass.

P.M.

1:00 **Lunch Hour**

B. F. MASSELL, M.D.

A. C. NOLKE, M.D.

J. B. BLODGETT, M.D.

Y. MORITA, M.D.

J. A. POLHEMUS, M.D.

ANCEL KEYS, M.D.

TOM D. SPIES, M.D.

R. W. WILKINS, M.D.

LEO LOEWE, M.D.

M. A. PERLSTEIN, M.D.

M. V. VELDEE, M.D.

C. S. STEVENSON, M.D.

FOURTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: H. M. POLLARD, M.D., Ann Arbor

Secretary: J. W. STRAYER, M.D., Niles

INTERNAL MEDICINE

2:00 "What's New in Vitamin and Hormone Treatment of Arthritis"

TOM D. SPIES, M.D., Birmingham, Alabama
Professor of Nutrition and Metabolism and Chairman of the Department, Northwestern University Medical School, Chicago; Director Nutrition Clinic, Hillman Hospital, Birmingham, Alabama

2:30 "Rauwolfia in Hypertension"

ROBERT W. WILKINS, M.D., Boston, Massachusetts
Professor of Medicine, Boston University School of Medicine; Associate Director, Evans Memorial, and Associate Physician-in-Chief, Massachusetts Memorial Hospitals; Chief of Hypertension Clinic, Massachusetts Memorial Hospitals

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "What's New in Diabetes"

HENRY T. RICKETTS, M.D., Chicago, Illinois
Professor of Medicine, Section on Metabolic Diseases, University of Chicago

4:30 "What's New in Antibiotics for the General Practioner"

LEO LOEWE, M.D., Brooklyn, N. Y.
Assistant Clinical Professor of Medicine, State University College of Medicine, N. Y.; Attending Physician, Jewish Hospital of Brooklyn

5:00 End of Fourth Assembly
(No evening MCI program)

FRIDAY, MARCH 9, 1956

A.M.
8:45 REGISTRATION—Top of Stairs, Fifth Floor, Sheraton-Cadillac Hotel

EXHIBITS OPEN—Fourth Floor, Sheraton-Cadillac Hotel

FIFTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: W. S. JONES, M.D., Menominee

Secretary: W. R. MULLEN, M.D., Pentwater

OBSTETRICS AND PEDIATRICS

A.M.
9:00 "What's New in Cerebral Palsy"

MEYER A. PERLSTEIN, M.D., Chicago, Illinois
Professor of Pediatrics, Cook County Hospital Post Graduate School; Associate Professor of Pediatrics, Northwestern University; Chief Neurology, Cook County Hospital

9:30 "Poliomyelitis Vaccine: Problems in Processing and Antigenic Value"

MILTON V. VELDEE, M.D., Palo Alto, California
Chairman, Department of Biology, Stanford Research Institute; Formerly Chief, Biologics Control Laboratory, National Institutes of Health

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "The Handling of Breech Presentation"

CHARLES S. STEVENSON, M.D., Detroit
Professor and Chairman, Department of Obstetrics and Gynecology, Wayne University College of Medicine; Chief Obstetrician, Herman Kiefer Hospital; Head Attending Gynecologist, Detroit Receiving Hospital; Associate Attending Staff, Grace Hospital; and Consulting Obstetrician, Detroit Memorial Hospital and Dearborn Veterans Hospital

11:20 **"Cystocele and Rectocele—Present-Day Indications for Correction, and Technical Advances"**
GEORGE S. SAYRE, M.D., Ypsilanti
Alternate Chief of Obstetrical Department, Beyer Memorial, Ypsilanti; Associate Staff in Obstetrics and Gynecology, St. Joseph's Mercy, Ann Arbor

11:40 **"Recent Advances in Medical Care of Children"**
ERNEST H. WATSON, M.D., Ann Arbor
Professor of Pediatrics, University of Michigan

12:00 **End of Fifth Assembly**

12:00 **DISCUSSION CONFERENCE**
Grand Ballroom, Sheraton-Cadillac Hotel
Leader: LESTER E. BAUER, M.D., Detroit
Participants: ARTHUR C. CURTIS, M.D., Ann Arbor; JOHN T. FERGUSON, M.D., Traverse City; MEYER A. PERLSTEIN, M.D., Chicago, Illinois; DAVID J. SANDWEISS, M.D., Detroit; GEORGE S. SAYRE, M.D., YPSILANTI; HERBERT E. SLOAN, M.D., Ann Arbor; CHARLES S. STEVENSON, M.D., Detroit; MILTON V. VELDEE, M.D., Palo Alto, California; ERNEST H. WATSON, M.D., Ann Arbor; and FREDERICK F. YONKMAN, M.D., Summit, New Jersey

P.M.

1:00 **Lunch Hour**


G. S. SAYRE, M.D.


E. H. WATSON, M.D.


F. F. YONKMAN, M.D.

SIXTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: K. H. JOHNSON, M.D., Lansing

Secretary: COLEMAN MOPPER, M.D., Detroit

GENERAL MEDICINE

P.M.

2:00 **"What's New in Drugs, 1956"**
FREDERICK F. YONKMAN, M.D., Summit, New Jersey
Vice President in Charge of Research, Ciba Pharmaceutical Products, Inc., Summit, N. J.; Member Research and Development Section of American Drug Manufacturers Association


A. C. CURTIS, M.D.

2:30 **"Tips on the Treatment of Skin Diseases"**
ARTHUR C. CURTIS, M.D., Ann Arbor
Professor and Chairman of Department of Dermatology, University Hospital


D. J. SANDWEISS, M.D.

3:00 **FINAL INTERMISSION TO VIEW EXHIBITS**

3:30 **"What is New in Ulcerative Colitis"**
DAVID J. SANDWEISS, M.D., Detroit
Chief of Section on Gastroenterology and Attending Physician, Sinai Hospital, Detroit; Associate Attending Physician in Internal Medicine, Harper Hospital; Associate Physician in Internal Medicine, Detroit Receiving Hospital


H. E. SLOAN, M.D.

3:50 **"Cardiac Arrest"**
HERBERT E. SLOAN, JR., M.D., Ann Arbor
Associate Professor of Surgery, University of Michigan Medical School

4:10 **"A New Approach to the Clinical Management and Treatment of Behavior Problems"**
JOHN T. FERGUSON, M.D., Traverse City
Staff Physician, State Hospital


J. T. FERGUSON, M.D.

4:30 **End of Sixth Assembly and the 1956 Michigan Clinical Institute**

COMMITTEE ON ARRANGEMENTS

1956 MICHIGAN CLINICAL INSTITUTE

L. W. HULL, M.D., Detroit, *Chairman*

W. S. JONES, M.D., Menominee, *President, Michigan State Medical Society*

R. H. BAKER, M.D., *Immediate Past President, Michigan State Medical Society*

L. FERNALD FOSTER, M.D., Bay City, *Secretary*
Representing Michigan State Medical Society

* * *

H. H. CUMMINGS, M.D., Ann Arbor

A. C. CURTIS, M.D., Ann Arbor

H. M. POLLARD, M.D., Ann Arbor

H. K. RANSOM, M.D., Ann Arbor

J. M. SHELDON, M.D., Ann Arbor
Representing University of Michigan School of Medicine, University of Michigan, Department of Postgraduate Medicine

* * *

MUIR CLAPPER, M.D., Detroit

E. H. FENTON, M.D., Detroit

W. S. REVENO, M.D., Detroit

NELSON TAYLOR, M.D., Detroit
Representing Wayne University College of Medicine and Wayne County Medical Society

* * *

F. J. KEMP, M.D., Pontiac

F. D. JOHNSON, M.D., Flint

W. S. JONES, JR., M.D., Menominee

P. W. KNISKERN, M.D., Grand Rapids

D. G. PIKE, M.D., Traverse City

A. J. SWINGLE, M.D., Benton Harbor

R. W. TEED, M.D., Ann Arbor

RALPH TEN HAVE, M.D., Grand Haven

J. M. WELLMAN, M.D., Lansing
Representing Out-State Practitioners, members of MSMS

* * *

A. E. HEUSTIS, M.D., Lansing

J. D. MONROE, M.D., Pontiac
Representing Michigan Department of Health and Michigan Health Officers Association

* * *

E. I. CARR, M.D., Lansing
Representing Michigan Foundation for Medical and Health Education, Inc.

* * *

W. B. COOKSEY, M.D., Detroit
Representing Michigan Heart Association

* * *

V. C. ABBOTT, M.D., Pontiac
Representing American College of Surgeons Regional Committee on Trauma

HOTEL RESERVATIONS

MICHIGAN CLINICAL INSTITUTE

Detroit, March 7-8-9, 1956

The reservation blank below is for your convenience in making your hotel reservation in Detroit. Please send your application to Miss Dorothy J. Gibb, Assistant Sales Manager, Sheraton-Cadillac Hotel, Detroit 31, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels

Michigan Clinical Institute

c/o Sheraton-Cadillac Hotel

Detroit 31, Michigan

Attention: Miss Dorothy J. Gibb, Assistant Sales Manager

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving March .....hour.....A.M.....P.M.....

Leaving March .....hour.....A.M.....P.M.....

Hotel of First Choice: .....

Second Choice: .....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....	.....	.....	.....
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.....	.....	.....	.....
.....	.....	.....	.....

Date ..... Signature .....

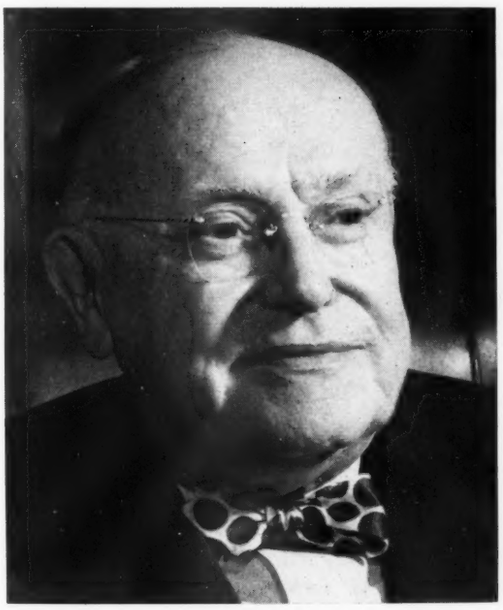
Address ..... City .....

John F. Wurz

A Practical Idealist in the Editor's Chair

John F. Wurz is a newspaper man and an idealist, with all the shrewdness that decades of newspaper editing develop, the moral earnestness that goes with idealism in any walk of life, and the sense of humor without which an idealist in a newspaper office is doomed.

The combination of humor, idealism and a discernment that recognizes evolving news as well as the full-blown article, has made John Wurz not only an effective newspaper executive but one who is happy in his job. He was born in 1885, but he's still in his office daily and can't be lured away with talk of midwinter vacations or any more relaxation than his modest three weeks a summer up north on his beloved Crystal Lake.



John Wurz's whole career has been associated with Michigan save for one brief tour of duty in Chicago. He was born in St. Joseph, and after graduating from St. Joseph High School, he went to the University of Michigan, where he was business manager of the *Michigan Daily.* The University had no separate Department of Journalism at that time but took its newspaper, as it does now, very seriously. A great deal of practical experience was to be accumulated in the newspaper office.

Wurz graduated in 1909 with the degree of Bachelor of Arts. Returning to St. Joseph, he became a reporter on the *St. Joseph Herald.* Not much later he became the youthful managing editor of the *Benton Harbor News-Palladium,* then worked on the *St. Joseph Herald Press.* From there, he went to Chicago and worked for a short time on the copy desk of the *Chicago Herald-Examiner,* next going to the *Kalamazoo Telegraph Press* as managing editor.

He joined the editorial staff of *The Grand Rapids Herald* on June 18, 1916. He became City Editor a short time later and has been heard to tell of days in World War I when newspaper manpower was so short that the City Editor found himself covering City Hall and County Building beats in addition to his regular duties.

From City Editor, Wurz was promoted before long to the position of Managing Editor. Staff members who worked under him in those days know that for many years the Managing Editor never left *The Herald* until the paper had been "put to bed." Theoretically, he took Sundays off, but as certainly as Sunday afternoon came, he turned up at the office.

Since January 1, 1948, John Wurz has been Editor of *The Grand Rapids Herald.*

During his earlier years on *The Herald,* he was closely associated with a man who went from the editorship of *The Herald* to a position of world influence, the late Senator Arthur H. Vandenberg, whose conception of bipartisan foreign policy still molds much American thinking.

From the beginning of his newspaper career, Wurz has taken a broad view of the responsibilities of the newspaper, not only as the organ of local information but as the medium of presenting general knowledge about world developments. Along with a keen appreciation of a story for its news value, he has stood for the ideal of the newspaper as a servant of the community, affording people the objective information that will enable them to make up their minds intelligently about issues and public personages.

Toward public officials who attempt to keep public affairs private, Wurz usually quiet and amiable, became a crusader. Closed meetings of public officialdom are anathema to him.

It is Wurz's general view of the newspaper as an instrument of all-important information that has led him to develop in *The Herald* the policy toward medical news that earned him the award for "distinguished health service," which he is to receive from The Council of the Michigan State Medical Society.

The Herald has always given careful, objective attention to medical news. When mass immunization with Salk polio vaccine was being organized, *The Herald* reported the developments from day to day, honestly, vigorously and independently. Through the complications that followed, *The Herald* followed the changing situation carefully, not taking sides, simply reporting the daily developments. When an important medical speaker is in town, a reporter is assigned to get the story, and then the story is checked for medical accuracy, either with the speaker himself or an authoritative spokesman.

Aside from his profession of newspaperman, John Wurz's interests center largely in his family. He was married to Lilah Hooper August 14, 1912, at St. Joseph. They have two children, John Frederick Wurz, M.D., who is a practicing physician in Grand Rapids, and Robert Hooper Wurz of Grand Rapids.

Mrs. Wurz, whose family had produced several physicians, has always had an active interest in health matters and for years devoted herself to getting the campaign against cancer firmly established in the Grand Rapids area. She was one of the founders of the Kent County Chapter of the American Cancer Society and served as its Commander.

Wurz is a member of the American Society of Newspaper Editors and of Rotary Club International. He attends the Church of St. Thomas the Apostle in Grand Rapids.

—MARGUERITE S. KERNS

MAKES YOU WONDER!

A recent study made by the Hartford County (Conn.) Medical Society of 144 obituaries of local physicians and probate court cases involving their estates reveals some illuminating—and startling—facts which should make any physician do a bit of checking on his own financial status and on just how fair he is being to his own health.

The study revealed the following, according to an article in the *Hartford Times* and abstracted by the New England Mutual Life Insurance Company's official bulletin, *The Pilot's Log:*

One out of eight of the physicians who died between 1940 and 1953 was in debt at the time of death.

Of the 144 doctor estates studied, one out of three . . . left net assets of less than $10,000.

The Hartford survey disclosed only one extremely wealthy doctor out of the 144 and that $575,915 of his estate was consumed by estate taxes and other settlement expenses.

Only one doctor in eight survived his wife!

The doctors aged forty to fifty died in a ratio of 2:1 as compared with the general population, and in the sixty to seventy bracket, the doctors' death rate was 50 per cent higher than that shown in the insurance table.

Heart diseases and cerebral hemorrhage were the chief causes of death.

Expenses of settlement of the estates studied ranged from a minimum of 13 per cent to as much as one third.

The age at death of the physicians when compared with life insurance mortality tables showed that there were two vulnerable age periods for medical men—forty to fifty and sixty to seventy.

One out of three physicians left no will.—*Muskegon County Medical Society Bulletin,* November, 1955.

President's Message

Do We Want Compulsory Social Security?

At its 1955 Annual Session in Grand Rapids, the MSMS House of Delegates considered a resolution concerning Old Age and Survivor's Insurance, better known as "Social Security." While the resolution as presented was disapproved, the House of Delegates very wisely requested each component County Society to conduct a poll among Society members to ascertain their position on the question.

Right now is the time to conduct this poll, while we still have the opportunity to express ourselves. This is a question upon which the opinion of every doctor of medicine in Michigan should be recorded—and soon, before Congress acts upon Social Security measures in its new session. The findings of this poll will help guide MSMS policy in its contact with Congress.

To me, it appears there are three primary questions to be answered when the doctor of medicine considers his attitude toward Federal Old Age and Survivor's Insurance:

1. **Are you for or against Social Security for physicians in its traditional form, as a *compulsory* obligation?**
2. **Do you favor *voluntary* Social Security?**
3. **Do you favor a reappraisal study of the Old Age and Survivors Insurance Program as a whole?**

There is little question that some type of Old Age and Survivor's Insurance is here to stay, but there are great doubts in the minds of many whether the program in its present form is "insurance" or whether it is a pension plan which will demand huge payments for the current income of future generations rather than from funds laid aside in reserve during the early years of the program. As Social Security now exists, today's young people—and their children and grandchildren—apparently are being saddled with an enormous debt which rapidly grows larger year by year.

There is also one final question which often comes to my mind: I wonder how many doctors in the State of Michigan would agree to retire at the age of sixty-five in order to draw the small benefits paid under the Social Security plan as it now stands?

In next month's Page, I shall continue the discussion of this controversial question.

W. S. Jones.

President, Michigan State Medical Society

Solid reasons for prescribing

ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

For nearly two years, ACHROMYCIN has been in daily use. Thousands of practicing physicians in every field have substantiated its advantages, and the confirmations mount every day.

In any of its many dosage forms, ACHROMYCIN has proved to be well tolerated by patients of every age. It provides true broad-spectrum activity, rapid diffusion, and prompt control of a wide variety of infections caused by Gram-negative and Gram-positive bacteria, rickettsia, and certain viruses and protozoa.

ACHROMYCIN—an antibiotic of choice, produced under rigid controls in Lederle's own laboratories.

LEDERLE LABORATORIES DIVISION *American Cyanamid Company* PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

Lederle

wide-spectrum activity

prompt control of infection

rapid diffusion

negligible side effects

chloride
Lederle

Editorial

THE NEW YEAR

The officers of the Michigan State Medical Society and the Publication Committee of THE JOURNAL wish all our members and readers a most happy and busy but satisfying New Year.

THE PRESIDENT'S HEALTH

ON the morning of July 2, 1881, as President James A. Garfield was entering a railway station at Washington, D. C., he was shot. He battled for life, lingering until September 19, when the Vice President succeeded. For two and one-half months the Presidency was much disturbed and hampered.

In the summer of 1919 President Woodrow Wilson had proposed a treaty with the Central powers, establishing the formula for the League of Nations. In an attempt to bring public opinion to bear upon Congress to accept the treaty, the President made a trip throughout the country and en route suffered a stroke which necessitated his return to Washington and his complete withdrawal from official contacts with the government. For many months, Mrs. Wilson was the only contact. She produced his signature when necessary but there were no cabinet meetings or other functions.

President Franklin D. Roosevelt's fourth term and the manifest impropriety of that nomination prompted us to publish in July, 1945, page 716, an editorial sharply outlining medical responsibility and honesty when making misleading reports under such circumstances.

The recent heart attack suffered by President Eisenhower has recalled this evident lack of precaution. We are unable to understand how a medical man charged with the health of not just a man, but the most important man in the world, would allow him (at his not too advanced age but an age when health matters need special care) to do the things reported on that day before the heart attack occurred. Our practice is restricted, but many of our patients ask advice about behavior in advancing age and we always caution against very strenuous living. If the President had been much less active, the coronary might still be in the future.

This brings up other editorial suggestions which we are repeating. Reread the editorial, "Health Surveys," pages 74-75, January, 1953. We quote three paragraphs:

"There is no provision in our government for carrying on the functions of the Presidency in case the President is incapacitated temporarily. Many people believe there should be a periodic appraisal of the President's health. This should not be made by a politically appointed or selected medical man. The regular care of the President's health is his own personal privilege, and he is entitled to his own private physician, be he an officer of the Army, Navy or civilian. There is an element of personal or political bias in that selection. That is the President's right as a free citizen."

"But the President is not a free citizen, insofar as he is President of the United States. He owes his best service to the people of this country. Some plan should be set up by Congress providing for an independent non-political appointment-free commission which shall periodically and at sufficiently frequent intervals make a thorough study of the President's health, mental and physical, to determine whether he is able and capable to carry on his arduous work. If found sound, the Commission shall so report; if found temporarily incapacitated, his duties could temporarily be assumed by the Vice President. If found permanently disabled, some provision should be made for an independent confirmation of that finding, in which case the Vice President should take over. . .

"The President is a living symbol of our government, and essential to the proper function of the government. We must protect his health, and also protect ourselves from the dangers which might develop if the burdens should prove too great."

We believe the misfortune which has hampered President Eisenhower is so evidently a threat that it is the duty of Congress to enact precautionary procedures.

OLD AGE AND SURVIVOR'S INSURANCE

IN 1954, the Congress amended and extended the Old Age and Survivor's Insurance Act, providing that beginning January 1, 1955, 58,800,000 persons are eligible to participate. It is compulsory except for a very few groups, and deductions are made from wages, 2 per cent (matched by the employer) for earnings up to $4,200 a year. Benefits are paid upon application and establishment of proof. If self-employed, the person must pay this tax with his income tax.

The maximum a retired worker may collect at present is $108.50 per month. If married and both husband and wife are over sixty-five, the maximum is $162.80 per month. If the worker continues to work and earn $1,200 a year he cannot draw any benefits at all except in months when his earnings are less than $80.

If the worker in the $4,200 income level dies, his wife (if over sixty-five) may draw $81.40 per month, or at any age if she has one child under eighteen, she may get $162.80 a month. If two children, the amount is $200.00. If she is in the lower income level, there are stated allowances for more than two children, but the maximum is $200.00. When the children reach eighteen, the widow, if under sixty-five, will receive no benefits until she reaches sixty-five, at which time her maximum will be $81.40 per month. At the present time the minimum a worker will receive upon retirement is $30.00 per month, man and wife $45.00, and the widow, or a surviving minor child, if sole heir, $30.00.

Economists, including Frank L. Dickinson, Ph. D., Director of A.M.A. Bureau of Economics, have outlined programs whereby one may provide equal or better protection through recognized insurance methods.

If a worker is disabled permanently, the new law provides that his earned benefits will not decrease under the averaging rule, but the period of his disability will be exempted from the figuring. He will however, have to wait until he is sixty-five before he may draw his benefits. A new bill (H.R. 7225) is now under consideration to which the AMA has taken exception. This new bill recognizes payment for permanent disabilities, advances the time of payment to age fifty and provides a controlled method of federally paid medical examinations to determine disability. It was passed in the House of Representatives without public hearing, with only thirty minutes of debate, and amendments prohibited. The bill is now in the Senate. We all believe any legislation of great moment should follow time-honored procedures and be voted upon only after suitable consideration. That objection to this legislation is basic and logical for anyone.

The medical profession has consistently objected to legislation which sets up controls of professional work as does the section in this amendment providing for determining amount and permanence of disability. We believe that is the privilege and duty of the claimant to be obtained from his private physician, just as so many other reports are made.

HOSPITAL COSTS

FREQUENTLY we hear complaints about the costs of hospital care. Just recently we quoted a letter to one of the newspapers from a prominent insurance man, remonstrating bitterly about the fact that a short hospital experience could use up the savings of years of frugality.

A study of records in seven representative hospitals in Michigan is very illuminating. We are quoting the costs per patient day:

Year	Personnel Costs	Other Costs	Total
1949	$13.59	$6.37	$19.96
1950	14.00	6.64	20.64
1951	15.41	7.14	22.55
1952	17.15	7.32	24.47
1953	18.14	7.32	25.46
1954	20.38	7.50	27.88

We are also giving the average gross monthly starting salaries for the following groups, comparing with U. S. averages.

		1949	1950	1951	1952	1953	1954
General duty nurses	U.S.	$212	$214	$224	$233	$242	$247
	Mich.	219	222	241	251	261	265
Practical nurses	U.S.	123	123	128	132	136	137
	Mich.	129	128	143	147	152	153
Clerks	U.S.	140	141	148	154	160	162
	Mich.	155	155	165	177	182	189
Untrained men	U.S.	146	147	155	160	166	170
	Mich.	146	150	164	168	175	181
Untrained women	U.S.	148	149	156	164	160	172
	Mich.	159	162	178	184	186	195

In every single item the Michigan salaries are higher than the United States average.

ON THE PROPER USE OF CYTOLOGY

RECENTLY the mails have been flooded with literature on the "Cancer Protection Plan" as proposed by the Cancer Cytology Foundation of America. Pamphlets describing a plan to establish regional cytology centers throughout the country were sent to 183,000 physicians and 60,000 civic and business leaders. The statement was made that this plan had been "now endorsed enthusiastically by the medical profession" and the article in *Spotlight* stated that cancer cytology is the "discovery of the century." It may be that this type of publicity will be of value in obtaining a greater acceptance of cytology by the physicians of the United States. However, one questions whether

this is the best method to employ. There has been steady progress in the years that have elapsed since Papanicolaou's publications and the increased use of this technique through the years has borne testimony to its usefulness. However, there are many physicians who know nothing about the potentialities of cytology and some pathologists who still maintain a stubborn resistance toward the acceptance of the value of cytology.

It is generally recognized that some malignancies can be diagnosed by cytologic means before there is any clinical evidence of the disease by physical examination. This technique has made possible diagnosis of certain malignancies, especially epidermoid carcinoma of the cervix, while still in an early and curable stage. Approximately 1 in 100 adult women who are presumably well will have abnormal cells in the vaginal and cervical smears which indicates the presence of squamous cell carcinoma.

There is then no room for argument as to whether the cytological techniques are of practical value and acceptance of these techniques is now so firmly established that candidates for certification by the American Board of Pathology must be able to show proficiency in cytodiagnosis. But there are serious objections to the ideas as set forth by the Cancer Cytology Foundation of America, Inc. A layman reading their material would gain the impression that a negative smear is proof that no cancer exists. This is definitely not true. Approximately 10 per cent of women with invasive carcinoma of the cervix will have negative smears.

A further objection lies in the fact that there are not nearly sufficient numbers of trained persons who can either screen or diagnose such a vast number of smears as would be involved in a mass program of the sort advocated. Patients are advised to get the smears made in their physicians' office and this is the right and proper procedure. The profession, as a whole, and important specialty organizations, such as the College of American Pathologists, the American Society of Clinical Pathologists and the Inter-Society Cytology Council, are definitely opposed to such a plan as described in *Spotlight*. It is generally conceded that:

1. Cytology (smear diagnosis) is a recognized laboratory procedure now widely offered by pathologists.

2. The test is rapidly becoming available to those desiring it.

3. It is in the best interest of the patient to maintain the closest possible professional relationship with the clinician caring for him and the pathologist endeavoring to interpret this material. In only this way can close correlation be obtained between clinical findings, cytologic examinations, and results of biopsy and therapy.

The best interests of the patient will be served if cytology is practiced in pathological laboratories where close co-operation between the attending physician and his pathologist can be maintained. Mail order laboratory service such as proposed by the Cancer Cytology Foundation of America, Inc., has never proved satisfactory.

HARRY M. NELSON, M.D.

ROLE OF THE PHYSIATRIST IN MODERN MEDICAL PRACTICE

COMMONLY, patients seek the advice of the medical profession primarily for relief of two complaints, pain and anxiety. It matters little to the patient whether we individually consider ourselves specialists in general practice or specialists in one of its multitudinous offspring. Our treatment falls into six categories. These are dietary, drugs, surgical, radiation, physical and psychotherapy. We, as physiatrists, frequently find it advisable to consult with a suitable specialist for confirmation of diagnosis, or concerning management or for specific treatment.

Payment for services is becoming daily one of the patient's great problems. He may finally wish he had had sufficient stoicism to endure the pain rather than the anxiety engendered by the cost to him of medical care. Within the last decade he has asked help of the actuarian for protection from the cost of medical care. He has found able allies in the medical profession and in the hospital administrators. The Blue Cross plan has been an exemplary buffer between the dictates of economical medical care and private medical care. By private medical care we mean the inviolable patient-physician relationship upon which medicine has prided itself for at least two thousand years.

There are those who believe that the high cost of medical care can only be met by the disruption

of this relationship between physician and patient. Their belief is given support by two widely diverse groups. On the one hand there are those outside the medical profession who recognize a good political tool and are actively promulgating methods to destroy the private practice of medicine in America.

However, these are the less dangerous of the two groups. The real danger lies within our own ranks. Our individual inertia increases the strength of the vociferous minority.

Ironically, the medical care of the past five decades has helped to create the problems which are increasing in frequency and severity. Our population has grown older because of the high quality of preventive and definitive medicine. Those of us specializing in rehabilitation are aiming to maintain the gains.

In rehabilitation medicine, emphasis shifts sharply to so-called drugless and knifeless therapy: but physical medicine, like pharmacology and surgery, has also the fine thread of psychiatry running through it. Unfortunately, the quackery which formerly surrounded those physicians who used physical modalities still tends to cloud the issue, and causes the physiatrist to be held suspect. It is not only a question of the physiatrist proving his ability to render service for which he is trained, but also that his colleagues come to know which problems he can assist them in.

The physician trained in physical medicine and rehabilitation is to see to it that efficient use of highly skilled adjunct personnel is made. There should be no disruption of the physician-patient relationship. By reason of his special training the physiatrist is in a position to prescribe treatment of referred patients to be rendered by such personnel as the physical, speech and occupational therapist, the clinical psychologist, the medical social worker, and the vocational counsellor.

It has been found that the training which the physiatrist has had frightens many of his colleagues. The majority still feels that the "physiotherapy" physician should stick to his bake and massage as directed by the physician referring a patient. As a result, the major part of the physiatrist's ability remains untapped. His skill in the diagnosis and management of many physical medicine problems, medical orthopedics, various neuromuscular disabilities, the arthritides and peripheral vascular diseases, when confined by attitudes as mentioned above, remains dormant.

How, then, can we make the transition from preventive and definitive medicine to rehabilitation medicine a smooth one? The physiatrist, with much to contribute to the former and the catalyst for the latter, has a definite responsibility. It cannot be done by giving lip service to the philosophy of rehabilitation, or even true belief in its advantages. It is important that methods be developed and those that are developed be used. Presently the two important techniques are the consultation technique and the joint clinic technique. The House of Delegates of the American Medical Association consistently has recommended that physical medicine, like radiology, pathology and anesthesiology, be practiced at a consultant level. This has been recommended to protect our profession from the practice of medicine by paramedical personnel and to protect vulnerable members of our profession from prostitution by hospital administrators. Should the American Medical Association ever allow any one of the above groups to become less a physician than other practitioners, the physician-patient relationship is in peril for all members of the American Medical Association. Every thoughtful practitioner will pause for reflection. There can be no room for professional jealousies. There is a great need for understanding and co-operation in effecting this and other policies recommended by the American Medical Association's House of Delegates.

The joint clinic technique is not new. The patient who needs rehabilitation has so many facets to his problem that concensus is necessary. The problems resulting from polio, severe rheumatoid arthritis, cerebral palsy, multiple sclerosis, hemiplegia and paraplegia do not resolve themselves around one medical specialty. Good medical care of the severely disabled requires group judgment. The specialist in physical medicine and rehabilitation is best trained to direct such a team. He knows how to get the best from the paramedical personnel. He also, by reason of his general training in medicine, is able to recognize when help from other specialties is indicated.

As insurance coverage increases percentagewise, there is more activity among the administrators of these plans that rehabilitation procedures be efficient and be economical. The cost of medical training is very high and the medical school curriculum filled to bursting. It is not reasonable to anticipate that each individual specialist will learn

all of the rehabilitation techniques and the use of all of the ancillary personnel without prolonging his residency training period for at least an additional year. This is perhaps unwise, for a majority of the rehabilitation techniques used for one patient are used for most of the others. The physiatrist spends his three years in specialty training mastering them all. A cord bladder, whether seen by the syphilologist or the neurosurgeon, as a result of multiple sclerosis or of neoplasm, is a disability which should be referred to the physiatrist who is experienced in training a cord bladder. A patient with cerebral palsy, whether diagnosed by the general practitioner, by the pediatrician, the neurologist, by the orthopedic surgeon, would benefit most by being referred to the physiatrist for training purposes and management.

Although the philosophy of rehabilitation is important, more emphasis should be placed on the methods and techniques of rehabilitation. The physiatrist is trained as any other physician with additional training in diagnostic techniques and medical care of a highly specific nature. The following is quoted in part from the *Journal* of the AMA for September 27, 1952, regarding specialty board examination for the physiatrist:

The clinical aspects of physical medicine and rehabilitation will include:

(a) Those diseases and conditions that come within the field of physical medicine and rehabilitation. These include arthritis and the various rheumatic diseases, neuromuscular diseases such as poliomyelitis, cerebral palsy, and paraplegia, and musculoskeletal diseases, including the large group of traumatic and orthopedic conditions.

(b) The clinical usage of such physical agents as heat, water, electricity, ultraviolet radiation, massage and exercise, et cetera.

(c) An understanding of the basic principles of physical medicine and rehabilitation and the ability to co-ordinate the services of such personnel as clinical psychologists, social service worker, vocational guidance worker, et cetera; the ability to prescribe specifically the therapy for patients for execution by the technical and ancillary personnel in a department of physical medicine and rehabilitation.

(d) A knowledge of the use of associated personnel within the field of physical medicine and rehabilitation such as the physical therapist, occupational therapist, clinical psychologist, and social service worker. This knowledge must include the ability specifically to prescribe patient care for execution by these therapeutic and technical groups.

Physical medicine and rehabilitation as a medical specialty is a product of our times. The two chief factors which have contributed to its growth are (1) the increasing age of our population and (2) the expansion of rapid communication. The result of these has been a marked rise in long-term illness. Psychiatric, cardiovascular and arthritic disabilities, coupled with the disabling aspects of highway, industrial, and especially home accidents, has inordinately increased the cost of medical care. No small portion of this increased cost has been the demand for expensive ancillary personnel. In some sections of the country, the salaries of ancillary professional personnel are in large measure paid by community and governmental agencies. This can and does disrupt the patient-physician rapport and is not too healthy a situation. Medical care rendered by these auxiliaries should be supervised by the practicing physician or a physician designated by his colleagues or through his medical society so that the patient-physician relationship is not exposed to dissolution.

The patient's physician should be a real leader and a source of guidance for medical care of this nature. He must have sufficient background and training to command the respect of referring agencies and paramedical personnel. Such a physician would be a physiatrist whose training does include all of these essentials. In this way, the physiatrist is taking his right and proper place in a society where health must be guarded through the integration of the various individuals and agencies.

To maintain the physician-patient relationship in such a setting is the basic contribution the physiatrist is destined to make to modern medical practice.

KATHRYN MCMORROW, M.D., M.P.H.

CANCER CONTROL

(Continued from Page 1412)

often be completely resected. Their early experience suggests that this may be possible in at least some types of residual cancers. In all the patients in whom the second-look operation proved effective, residual cancer was limited to one or a few lymph nodes and to one area of the abdomen. For patients with this type of residual cancer, the second-look procedure may prove to be a crucial addition to therapy.

MSMS Ninetieth Annual Session—1955

		Introduction of Business	Reference Committee Report	
I.	Record of Attendance (Roll Call)	1490		
II.	President's Address	1491	1506	approved
III.	President-Elect's Address	1492	1506	approved
IV.	Reports of The Council (including Annual Reports of Committees of The Council)	1492	1509	approved as amended re assessment
V.	Report of Delegates to American Medical Association	1496	1506	approved
VI.	Report of President, Woman's Auxiliary to the Michigan State Medical Society	1498	1506	approved
VII.	Report of President, Michigan State Medical Assistants Society	1498	1506	approved
VIII.	Selection of Michigan's Foremost Family Physician	1499		
IX.	Resolutions and Motions:			
	1. Resolution re Periodic Health Examinations by Hospital Staffs	1499	1507	approved
	2. Resolution re Appreciation of Public Service Rendered by R. L. Novy, M.D., Detroit (Wayne and Genesee)	1499	1512	approved
	3. Resolution re Beaumont Memorial preservation	1499	1508	approved
	4 Resolution re Joint Commission on Accreditation of Hospitals	1500	1510-11	referred to introducer for clarification
	5. Resolution re Screening of Foreign Interns	1500	1508	approved
	6. Resolution of Appreciation of Public Service Rendered by R. L. Novy, M.D., Detroit (Berrien)	1500	1512	approved
	7. Resolution re Jenkins-Keogh Bill	1500	1507	approved
	8. Resolution re Medic—commendation to Los Angeles County Medical Society	1501	1508	approved
	9. Resolution re Medical Representation on Voice of America	1501	1512	approved
	10. Resolution re Propaganda on Salk Vaccine	1501	1514	substitute approved
	11. Resolution re County Society Membership	1501	1507	disapproved
	12. Resolution re Hospital Privileges	1501	1512	approved as amended
	13. Resolution re Fluoridation of Water	1502	1514	disapproved
	14. Resolution re Hospital Facilities for the Mentally Ill	1602	1509	approved as amended
	15. Resolution re Increasing Hospital Personnel for the Mentally Ill	1502	1508	referred to Mental Health Committee
	16. Resolution re Old Age and Survivor's Insurance Program	1502	1512	disapproved with recommendation of county society poll of members
	17. Resolution re Fee for Examination of Mentally Ill	1503	1508	approved
	18. Resolution re Pollution of Inland Waterways	1503	1515	substitute approved
	19. Resolution re Optometric Legislation	1503	1513	approved
	20. Resolution re Election of Executive Committee of The Council	1503	1507	disapproved
	21. Resolution re Study of Surgical Fees (MMS)	1503	1516	approved as amended
	22. Resolution re Blue Shield Reporting in Mediation Cases	1504	1516	substitute approved
	23. Resolution re Contributions to Beaumont Memorial	1504	1513	approved as amended
	24. Resolution re Creation of Occupational Health Section	1504	1508	approved
	25. Resolution re Driver Training	1504	1508	approved
	26. Resolution re AMA Study Committee on Highway Accidents	1504	1513	approved
	27. Resolution re Expansion of AMA Administrative Facilities	1504	1513	substitute approved
	28. Resolution re Non-Scientific Sessions at AMA Conventions	1505	1514	substitute approved
	29. Resolution re Appreciation of Service Rendered by L. A. Drolett, M.D., Lansing	1505	1508	approved
	30. Resolution re Speedy Recovery for President Eisenhower	1506	1515	approved
	31. Resolution re Committee on Division of Fees (MMS)	1506	1516	approved
	32. Resolution re California Cancer Commission	1508	1514	approved
X.	Reports of Standing Committees:			
	1. Postgraduate Medical Education	1505	1511	
	2. Preventive Medicine and Its Subcommittees	1505	1511	
	3. Public Relations	1505	1512	
	4. Ethics	1505	1512	
	5. Legislative	1505	1512	
XI.	Reports of Special Committees:			
	1. Beaumont Memorial	1506	1506	
	2. Scientific Radio	1506	1507	
	3. Advisory to Woman's Auxiliary	1506	1507	
	4. Advisory to Michigan State Medical Assistants Society	1506	1507	
	5. Mediation	1506	1507	

		Introduction of Business	Reference Committee Report
XII.	Reports of Reference Committees:		
	1. *On Officers Reports:* (a) President's Address—1506; (b) President-Elect's Address—1501; (c) Delegates to AMA—1506; (d) President, Woman's Auxiliary to MSMS—1506; (e) President, MSMAS—1506.		
	2. *On Reports of The Council:* (a) Council's two Annual Reports—1509; (b) Resolution on Joint Commission on Accreditation of Hospitals—1510-11.		
	3. *On Reports of Standing Committees:* (a) Postgraduate Medical Education—1511; Preventive Medicine and its Subcommittees—1511; (c) Public Relations—1512; (d) Ethics—1512; (e) Legislative —1512.		
	4. *On Reports of Special Committees:* (a) Beaumont Memorial—1506; (b) Scientific Radio—1507; (c) Advisory to Woman's Auxiliary—1507; (d) Advisory to MSMAS—1507; (e) Mediation—1507.		
	5. *On Constitution and By-Laws:* (a) Resolution re County Society membership—1507; (b) Resolution re Election of Executive Committee of The Council—1507.		
	6. *On Resolutions:* (a) Resolution re Appreciation of Public Service Rendered by R. L. Novy, M.D. (Wayne and Genesee) —1512; (b) Resolution re Appreciation of Public Service Rendered by R. L. Novy, M.D. (Berrien) —1512; (c) Resolution re Medical Representation on Voice of America—1512; (d) Resolution re Hospital Privileges—1512; (e) Resolution re Old Age and Security Insurance Program—1512; (f) Resolution re Possible Optometric Legislation—1513; (g) Resolution re Contributions to Beaumont Memorial—1513; (h) Resolution re AMA Study Committee on Highway Accidents—1513; (i) Resolution re Expansion of AMA Administrative Facilities—1513; (j) Resolution re non-scientific Sessions at AMA Conventions—1514; (k) Resolution re California Cancer Commission—1514.		
	7. *On Special Memberships*		1515
	8. *On Legislation and Public Relations:* (a) Resolution re Periodic Health Examinations by Hospital Staffs—1507; (b) Resolution re Jenkins-Keogh Bill—1507; (c) Resolution on Screening of Foreign Interns—1508; (d) Resolution re Beaumont Memorial Preservation—1508; (e) Resolution re Fee for Examination of Mentally Ill—1508; (f) Resolution re Driver Training—1508; (g) Resolution re Hospital Facilities for the Mentally Ill—1508, 1509; (h) Resolution re Increasing Hospital Personnel for Mentally Ill—1508.		
	9. *On Hygiene and Public Health:* (a) Resolution re Propaganda on Salk Vaccine—1514; (b) Resolution re Fluoridation of Water—1514; (c) Resolution re Pollution of Inland Waterways—1515.		
	10. *On Miscellaneous Business:* (a) Resolution re Appreciation of Service rendered by L. A. Drolett, M.D.—1508; (b) Resolution re Medic —Commendation to Los Angeles County Medical Society—1508; (c) Resolution re Creation of Occupational Health Section—1508; (d) Resolution re Speedy Recovery of President Eisenhower—1515.		
	11. *On Medical Service and Prepayment Insurance:* (a) Resolution re Study of Surgical Fees (MMS)—1516; (b) Resolution re Committee on Division of Fees (MSMS)—1516; (c) Resolutions re Blue Shield Reporting in Mediation Cases—1516.		
XIII.	*Miscellaneous:*		
	1. In Memoriam to Past Members, House of Delegates		1491
	2. In Memoriam to Stewart A. Campbell		1495
	3. ATAE Grand Award Won by MSMS		1498
XIV.	*Elections:* (1) Councilor, 2nd District—1517; (2) Councilor, 3rd District—1517; (3) Councilor, 15th District—1517; (4) Councilor, 16th District—1517; (5) Delegates to AMA —1517; (6) Alternate Delegates to AMA—1518; (7) President-Elect—1518; (8) Councilor, 1st District—1518; (9) Speaker—1518; (10) Vice Speaker—1540.		1517

MSMS House of Delegates—1955

Summary of Proceedings

The 90th Annual Session of the Michigan State Medical Society's House of Delegates was held in Grand Rapids, September 26-27, 1955.

The House of Delegates:

1. Adopted with thanks the President's Address, the President-Elect's Address, the report of Delegates to the American Medical Association, the Annual Report of the President, Woman's Auxiliary to the Michigan State Medical Society, and the Annual Report of the President, Michigan State Medical Assistants Society.
2. The Annual Reports of The Council (including the Annual Reports of Committees of The Council) were adopted as amended (re assessment for 1956).
3. Adopted Annual Reports of all Standing Committees and of all Special Committees of the Society.
4. Elected Walter H. Winchester, M.D., Flint, as Michigan's Foremost Family Physician for 1955.
5. Adopted resolutions concerning: (a) appreciation of public service rendered by R. L. Novy, M.D., Detroit; (b) Beaumont Memorial preservation; (c) screening of foreign interns; (d) Jenkins-Keogh Bill; (e) "Medic"—commendation to the Los Angeles County Medical Society; (f) medical representation on Voice of America; (g) fee for examination of mentally ill; (h) possible optometric legislation; (i) creation of Occupational Health Section; (j) driver training; (k) AMA Study Committee on Highway Accidents; (l) appreciation of service rendered by L. A. Drolett, M.D., Lansing; (m) speedy recovery for President Eisenhower; (n) Committee on Division of Fees (MMS); (o) California Cancer Commission; (p) periodic health examinations by hospital staffs; (q) hospital privileges (approved as amended); (r) hospital facilities for the mentally ill (approved as amended); (s) study of surgical fees—Blue Shield (approved as amended); (t) contributions to Beaumont Memorial (approved as amended).
   Adopted substitute resolutions concerning: (a) propaganda on Salk vaccine; (b) pollution of inland waterways; (c) Blue Shield reporting in mediation cases; (d) expansion of AMA administrative facilities; (e) non-scientific sessions at AMA Conventions.
   Referred: (a) to introducer, for clarification, a resolution re Joint Commission on Accreditation of Hospitals; (b) to MSMS Mental Health Committee for study a resolution re increasing hospital personnel for the mentally ill.
6. Disapproved resolutions concerning: (a) county society membership; (b) fluoridation of water; (c) old age and survivors insurance program—but recommended that county medical societies conduct polls of their memberships on this question; (d) election of Executive Committee of The Council
7. Elected to Special Memberships:
   (a) Thirty-five members to Life Membership: (Bay) Aloysius J. Zaremba, M.D., Bay City; (Branch) Kendall B. Rees, M.D., Coldwater; (Dickinson-Iron) George H. Boyce, M.D., Iron Mountain; (Genesee) Clifford P. Clark, M.D., Coral Gables, Florida; Lafon Jones, M.D., Flint, and Edwin E. Miller, M.D., Flint; (Ionia-Montcalm) Robert H. Haskell, M.D., Northville; Lee E. Kelsey, M.D., Lakeview, and Isaac S. Lilly, M.D., Stanton; (Jackson) Edward W. Douglas, M.D., Jackson; Walter L. Finton, M.D., Jackson, and Frank F. Pray, M.D., Jackson; (Kalamazoo) Dirk J. Scholten, M.D., Kalamazoo; (Menominee) Henry T. Sethney, M.D., Menominee; (Midland) Joseph H. Sherk, M.D., Midland; (St. Joseph) Charles G. Miller, M.D., Sturgis; (Washtenaw) Howard H. Cummings, M.D., Ann Arbor; Warren E. Forsythe, M.D., Ann Arbor; Christopher G. Parnall, M.D., Ann Arbor, and Inez R. Wisdom, M.D., Ann Arbor; (Wayne) Alexander W. Blain, M.D., Frederick H. Cole, M.D., William A. Defnet, M.D., Martin S. Dubpernell, M.D., Samuel Glassman, M.D., Fred L. Honhart, M.D., Charles J. Jentgen, M.D., E. V. Joinville, M.D., George M. Laning, M.D., Elbert A. Martin, M.D., William O. Merrill, M.D., Plinn F. Morse, M.D., Fred W. Organ, M.D., John B. Rieger, M.D., and Susanne M. Sanderson, M.D., all of Detroit.
   (b) Seven members to Retired Membership: (Bay) Edward S. Huckins, M.D., Bay City; (Calhoun) Theodore Kolvoord, M.D., Battle Creek; (Delta-Schoolcraft) John J. Walch, M.D., Escanaba; (Wayne) John R. Boland, M.D., Jerome W. Ankley, M.D., Ray D. Schirack, M.D., Bertrand C. Switzer, M.D., all of Detroit.
   (c) Seventeen members to Associate Membership: (Delta-Schoolcraft) Gilbert W. Benson, M.D., Escanaba; (Eaton) Richard K. Meinke, M.D., Rochester, Minnesota; (Muskegon) Robert G. Heneveld, M.D.; (Wayne) Henry A. Archambault, M.D., Detroit; Dorothy Fisher Caton, M.D., Detroit; Charles M. Ebner, M.D., Detroit; Martin Z. Feldstein, M.D., Detroit; Dunbar P. Gibson, M.D., Detroit; Gene L. Hackleman, M.D., Dearborn; Ralph G. Hubbard, M.D., Detroit; Werner K. Kersten, M.D., Detroit; Francine Larson, M.D., Wyandotte; Nur M. Malik, M.D., India; Charles W. Park, M.D., Detroit; Eugene V. Perrin, M.D., Washington, D. C.; Jack C. Smith, Detroit, and Vincent J. Turcotte, M.D., Detroit.
8. Elected the following officers:
   (a) A. E. Schiller, M.D., Detroit, as Councilor of the 1st District (1960).
   (b) O. B. McGillicuddy, M.D., Lansing, as Councilor of the 2nd District (1960).
   (c) G. W. Slagle, M.D., Battle Creek, as Councilor of the 3rd District (1960).
   (d) D. Bruce Wiley, M.D., Utica, as Councilor of the 15th District (1960).
   (e) G. Thomas McKean, M.D., Detroit, as Councilor of the 16th District (1960).
   (f) J. S. DeTar, M.D., Milan (1957); W. A. Hyland, M.D., Grand Rapids (1957); and C. I. Owen, M.D., Detroit (1957), as Delegates to the American Medical Association.
   (g) W. W. Babcock, M.D., Detroit (1957); E. F. Sladek, M.D., Traverse City (1957); O. J. Johnson, M.D., Bay City (1957); and Wm. Bromme, M.D., Detroit (1956), as Alternate Delegates to the American Medical Association.
   (h) Arch Walls, M.D., Detroit, as President-Elect.
   (i) J. E. Livesay, M.D., Flint, as Speaker, House of Delegates
   (j) K. H. Johnson, M.D., Lansing, as Vice Speaker, House of Delegates.

Michigan State Medical Society

Ninetieth Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION
September 26, 1955

The 90th annual session of the House of Delegates of the Michigan State Medical Society, held at the Pantlind Hotel, Grand Rapids, Michigan, on September 26-27, 1955, convened at 10:10 a.m., J. E. Livesay, M.D., Speaker of the House of Delegates, presiding.

I. RECORD OF ATTENDANCE

Office	*Officer*	*Meetings*				
		1st	*2nd*	*3rd*	*4th*	*5th*
Speaker	J. E. Livesay, M.D.	x	x	x	x	x
Vice Speaker	K. H. Johnson, M.D.	x	x	x	x	x
Secretary	L. Fernald Foster, M.D.	x	x	x	x	x
Immediate Past President	L. W. Hull, M.D.	–	–	–	–	–
County	*Delegate*					
1. Allegan	L. F. Brown, M.D.	x	x	x	x	x
2. Alpena-Alcona-Presque Isle	E. S. Parmenter, M.D.	x	x	x	x	x
3. Barry	A. B. Gwinn, M.D.	x	x	x	x	x
4. Bay-Arenac-Iosco	O. J. Johnson, M.D.	x	x	x	x	x
	D. A. Bowman, M.D.	x	x	x	x	x
5. Berrien	D. W. Thorup, M.D.	x	x	x	x	x
	N. J. Hershey, M.D.	x	x	x	x	x
6. Branch	H. J. Meier, M.D.	x	x	–	–	x
7. Calhoun	H. C. Hansen, M.D.	x	x	x	x	x
	L. R. Keagle, M.D.	x	x	x	x	x
8. Cass	S. L. Loupee, M.D.	x	x	x	x	x
9. Chippewa-Mackinac	W. F. Mertaugh, M.D.	x	x	x	x	x
10. Clinton	F. W. Smith, M.D.	x	x	x	x	x
11. Delta-Schoolcraft	H. Q. Groos, M.D.	x	x	x	x	x
12. Dickinson-Iron	L. E. Irvine, M.D.	x	x	x	x	x
13. Eaton	P. H. Engle, M.D.	x	x	–	–	x
14. Genesee	F. D. Johnson, M.D.	x	x	x	x	x
	C. W. Colwell, M.D.	x	x	x	x	x
	R. M. Bradley, M.D.	x	x	x	x	x
	C. K. Stroup, M.D.	x	x	x	x	x
	F. W. Baske, M.D.	x	x	x	x	x
15. Gogebic	D. C. Eisele, M.D.	x	x	x	x	x
16. Grand Traverse-Leelanau-Benzie	D. G. Pike, M.D.	x	x	x	x	–
17. Gratiot-Isabella-Clare	M. G. Becker, M.D.	x	x	x	x	x
18. Hillsdale	A. W. Strom, M.D.	x	x	x	x	x
19. Houghton-Baraga-Keweenaw	P. S. Sloan, M.D.	x	x	x	x	x
20. Huron	C. W. Oakes, M.D.	x	x	x	x	x
21. Ingham	J. M. Wellman, M.D.	x	x	x	x	x
	F. L. Troost, M.D.	x	x	x	x	x
	O. B. McGillicuddy, M.D.	x	x	x	x	x
22. Ionia-Montcalm	H. W. Harris, M.D.	x	x	x	x	x
23. Jackson	Glenn W. House, M.D.	x	x	x	x	x
24. Kalamazoo	W. A. Wickham, M.D.	x	x	x	x	x
	C. R. Lenz, M.D.	x	x	x	x	x
	F. C. Ryan, M.D.	x	x	x	x	x
	W. A. Scott, M.D.	x	x	x	x	x
	S. E. Andrews, M.D.	x	x	x	x	–
25. Kent	Paul Cooper, M.D.	–	–	–	–	x
	L. C. Carpenter, Jr., M.D.	x	x	x	x	x
	W. C. Beets, M.D.	x	x	x	x	x
	G. W. DeBoer, M.D.	x	x	x	x	x
	K. E. Fellows, M.D.	x	x	x	x	x
	W. J. Fuller, M.D.	x	x	x	x	x
	R. A. Rasmussen, M.D.	x	x	x	x	x
	A. V. Wenger, M.D.	x	x	x	x	x
	D. J. O'Brien, M.D.	x	x	x	x	x
26. Lapeer	G. C. Wilson, M.D.	x	x	x	x	x
27. Lenawee	H. C. Hill, M.D.	x	x	x	x	x
28. Livingston	T. W. Thompson, M.D.	Not Represented				
29. Luce	Sydney Scher, M.D.	–	–	x	x	x
30. Macomb	E. A. Oakes, M.D.	x	x	x	x	x
31. Manistee	A. S. Narotzky, M.D.	x	x	x	x	x
32. Marquette-Alger	H. G. Bacon, M.D.	x	x	x	x	x
33. Mason	Paul Ivkovich, M.D.	x	x	x	x	–
34. Mecosta-Osceola-Lake	J. R. Heidenreich, M.D.	x	x	x	x	x
35. Menominee	H. L. Gordon, M.D.	x	x	–	x	x
36. Midland	T. A. McDonald, M.D.	x	x	x	x	x
37. Monroe	R. D. Risk, M.D.	x	x	x	x	x
38. Muskegon	N. W. Scholle, M.D.	x	x	x	x	x
39. Newaygo	J. P. Klein, M.D.	x	x	x	x	x
40. North Central	E. H. Rodda, M.D.	x	x	x	x	x
41. Northern Michigan	J. R. Rodger, M.D.	x	x	x	x	x
42. Oakland	H. A. Furlong, M.D.	x	x	x	x	x
	E. B. Cudney, M.D.	x	x	x	x	x
	Otto O. Beck, M.D.	x	x	x	x	–
	J. M. Markley, M.D.	x	x	x	–	–
	N. F. Gehringer, M.D.	x	x	x	x	x
	E. W. Bauer, M.D.	x	x	x	x	–
	W. G. Robinson, M.D.	x	x	x	x	x
43. Oceana	W. F. Strong, M.D.	Not represented				
44. Ontonagon	Otto Van Der Velde, M.D.	x	x	x	x	x
45. Ottawa	J. P. Markey, M.D.	x	x	x	x	x
46. Saginaw	M. F. Bruton, M.D.	x	x	x	x	x
	A. C. Stander, M.D.	x	x	x	x	x
	K. T. McGunegle, M.D.	x	x	x	x	x
47. Sanilac	C. L. Weston, M.D.	x	x	x	x	x
48. Shiawassee	J. F. Beer, M.D.	x	x	x	x	x
49. St. Clair	S. A. Fiegel, M.D.	x	x	x	x	x
50. St. Joseph	L. L. Savage, M.D.	x	x	x	x	x
51. Tuscola	R. W. Spalding, M.D.	x	x	x	x	x
52. Van Buren	O. K. Engelke, M.D.	x	x	x	x	x
53. Washtenaw	R. W. Teed, M.D.	x	x	x	x	x
	P. S. Barker, M.D.	x	x	x	x	x
	G. H. Bauer, M.D.	x	x	x	x	x
	H. F. Falls, M.D.	x	x	x	x	–
	M. A. Darling, M.D.	x	x	x	x	x
54. Wayne	L. R. Leader, M.D.	x	x	x	x	x
	M. R. Weed, M.D.	x	x	x	x	x
	J. J. Lightbody, M.D.	x	x	x	–	x
	E. A. Osius, M.D.	x	x	x	x	x
	E. H. Fenton, M.D.	x	x	x	x	x
	G. C. Penberthy, M.D.	x	x	x	x	x
	C. I. Owen, M.D.	x	x	x	x	x
	W. W. Babcock, M.D.	x	x	x	x	–
	D. I. Sugar, M.D.	x	x	x	x	x
	G. S. Bates, M.D.	x	x	x	x	x
	L. J. Bailey, M.D.	x	x	x	x	x
	J. B. Blodgett, M.D.	x	x	x	x	–
	E. G. M. Krieg, M.D.	x	x	x	x	–
	J. E. Loftstrom, M.D.	x	x	x	x	–
	W. L. Brosius, M.D.	x	x	x	x	x
	A. D. Ruedemann, M.D.	x	x	x	x	x
	R. F. Fenton, M.D.	x	x	x	x	x
	C. K. Hasley, M.D.	x	x	x	x	x
	C. W. Sellers, M.D.	x	x	x	x	x
	A. E. Schiller, M.D.	x	x	x	x	x
	R. V. Walker, M.D.	x	x	x	x	x
	C. L. Candler, M.D.	x	x	–	x	x
	Louis Jaffe, M.D.	x	x	x	x	–
	R. H. Pino, M.D.	x	x	x	x	x
	C. E. Umphrey, M.D.	x	x	x	x	x
	J. E. Croushore, M.D.	x	x	x	x	x
	H. B. Fenech, M.D.	x	x	x	x	x
	E. H. Lauppe, M.D.	x	x	x	x	x
	F. P. Rhoades, M.D.	x	x	x	x	x
	M. L. Lichter, M.D.	–	–	x	x	x
	E. C. Texter, M.D.	x	x	x	x	x
	L. S. Fallis, M.D.	x	x	x	x	x
	P. C. Gittins, M.D.	x	x	x	x	x
	S. E. Gould, M.D.	x	x	x	x	–
	Joseph Hickey, M.D.	x	x	x	x	x
	E. A. Bicknell, M.D.	x	x	x	x	x
	L. A. Pratt, M.D.	x	x	x	x	x
	J. A. Kasper, M.D.	x	x	x	x	x
	Sidney Adler, M.D.	x	–	x	x	x
	W. L. Sherman, M.D.	x	x	x	x	–
	W. L. Foster, M.D.	x	x	x	x	x
	J. D. Fryfogle, M.D.	x	x	x	–	–
	E. C. Long, M.D.	x	x	x	x	x
	Clarke McColl, M.D.	x	x	x	x	x
	E. C. Baumgarten, M.D.	x	x	x	x	–
	I. C. Berlien, M.D.	x	x	x	x	x
55. Wexford-Missaukee	R. V. Daugharty, M.D.	x	x	x	x	x

IN MEMORIAM

Each year at this time we announce the names of former members of this House who have passed away. I will also announce the passing of sixty-two members of the Michigan State Medical Society since we last met.

Former delegates and alternates were:

Jackson County—J. J. O'Mera, M.D.

Kent County—P. W. Willits, M.D.

Livingston County—H. G. Huntington, M.D.

North Central Counties—Claude R. Keyport, M.D.

Oceana County—J. H. Nicholson, M.D.

Washtenaw County—Dean W. Myers, M.D.; John A. Wessinger, M.D.

Wexford County—C. E. Merritt, M.D.

Wayne County—Ralph H. Bookmyer, M.D.; Linus J. Foster, M.D.; Frank L. Ryerson, M.D.

May we rise, please, and have a moment of silence.

II. PRESIDENT'S ADDRESS

By R. H. Baker, M.D.

As my term of office as your President ends, I thank you for the honor you have bestowed on me and for a most thrilling and enlightening experience. I had no delusions of my own importance as I assumed this office, and I am more convinced now that I have been but a cog in our wheel of society leadership. My deepest appreciation is tendered to all who have carried on the activities of this Society in 1955. All of our officers and administrative staff have extended to me their help and loyalty. I cannot adequately thank them in words for their generous consideration.

The Council, as always, has carried the load which lightens the work and responsibility of any President. To them I am deeply grateful. Just knowing intimately such fine men is ample compensation for a busy year in office.

And to all committees I am grateful for the hours of sacrifice and effort devoted to their various accomplishments.

To my loyal wife, who has tolerated me and encouraged me this past year, I must express my deep gratitude and affection. A President's wife must put up with much disorganization of her life during her husband's term of office.

I shall not attempt to give you a strict accounting of my year as your President. Our activities are a matter of record. I have failed to achieve much of what I had hoped to do. I thank God I have been permitted to complete my year in spite of some annoying physical ailments; but my experiences have left me with some impressions that I will attempt to convey to you.

I began my year with a desire to reach down to the roots of our membership and study their opinions. I hoped to extend unity where it was indicated, and to promote indoctrination in the objectives and responsibilities of all doctors in their county and state societies.

As may be expected, I found that the work is done by a few—the officers and committees. The rank and file are not vocal of their desires. There is not enough continuity in office, especially that of Secretary.

I was pleased to note that there was less evidence than formerly of personal jealousies that used to lead to caustic criticism and even contributed to malpractice suits. I believe that medical organization has served to stem this tide.

There is still evidence that some men fail to understand or value the objectives of organized medicine. There are those who frequently say that our Society "does not speak for them." Of this I will comment later.

The broadened scope of our Society interest still leaves us with the basic one of stimulating and aiding scientific advancement in medical practice. This we are meeting in many ways, namely, by this convention.

Constantly changing demands from many sources must keep us alert and responsive to economic factors. We must keep our fees constantly defensible against the demands of public criticism. We must not ignore fee splitting where it exists, but be not drawn into controversy where faulty definitions of fee splitting cause argument. The efforts of mediation committees must continue within the boundaries of mediation. Malpractice needs better law enforcement.

Every physician should improve his knowledge of medical insurance, whether it be group prepayment for services, or any other form of commercial or compensation insurance. This will aid him in his practice and his advice to patients.

Our best public relations must be extended and applied by every doctor in his practice, and by all societies, large and small.

Our legislative interests and contacts are increasing at a rapid pace. No one can afford to be uninformed nor to ignore their opportunities to aid in supporting good medical legislation. This obligation holds for much national legislation that affects doctors.

In the field of hospital-physician relationship, I wish to quote from an address by Charles L. Farrel, M.D., at the Conference of Presidents in Atlantic City in 1955. He quotes from *Trustee,* a hospital booklet, in 1954, on the hospital's duty to the staff physician:

"Protection from discrimination on the grounds of race, creed or color should be afforded by the hospital trustees. Nor should the physician have to go about in fear of arbitrary or capricious action by the medical staff or the trustees of the hospital that might terminate his appointment or curtail his privileges without cause."

Dr. E. J. McCormick, Past President of the American Medical Association, stated: "Hospitals should not be centers for specialists, and it never was the ideal of the American Medical Association or the American College of Surgeons or any of the boards to establish a system whereby qualified physicians would be denied the facilities necessary to give good medical care to the people."

Dr. George M. Lewis of New York is quoted as follows: "It is true that the onus of proof might well be on a non-certified applicant for a hospital position to demonstrate his competence. However, once that competence has been proved, either through long service or otherwise, discrimination against him as non-certified cannot be justified. The board certificate should never be used as a weapon." Let us make that a reality, not just a statement.

Dr. Farrel then adds: "How often, however, have the very criteria designed to protect doctors, hospital and patient been subverted at the local level by various selfish forces acting under the guise of 'elevating standards.'"

To me, hospital-physician relationships are most important for our intraprofessional attention and activity. The public is crying for more general practitioners. It should be our deep concern to avoid any imbalance between specialists and general practitioners of medicine. We have been educated to believe that the hospital provides, in some cases, a chance for better medical care. Let not the general practitioner be denied this tool to better quality practice of medicine.

Again, I ask you, does your Society speak for you? This question applies to all levels, from the American Medical Association down to the state and county

levels. I put the American Medical Association first because they are the most remote from control by individuals in any county society.

There still seems to be a need for better understanding of how our democratic organization functions. Does the membership that you delegates represent feel that they have no voice in our activities and decisions? Don't let anyone neglect his right and responsibility to be heard as a medical citizen.

I trust the delegates before me realize their freedom to offer ideas, to discuss them freely in the House, and thereby set the policies that are further advanced to our representatives to the American Medical Association. If you know a better way to practice democratic privilege, yours is the responsibility for policy making.

I urge that you have confidence in your elected officers. In the course of a year's activities you must trust your officers and Councilors to carry on many policies already established, and to meet new and often perplexing problems. Their decisions are made with thought and deliberation to safeguard the interest of all our membership. If you question the soundness of their decisions, be sure you have the facts before you start a backfire of discontent and criticism.

My experience in this House and as an officer in the Society convinces me of the integrity of our elected leadership. May it always continue with an open-mindedness to progress.

Thanks, and my best wishes for our continued leadership in medical organization.

* * *

THE SPEAKER: This address will be referred to the Reference Committee on Officers' Reports.

III. PRESIDENT-ELECT'S ADDRESS

By W. S. Jones, M.D.

While socialized medicine still faces the medical profession, it is not our only serious problem that must be solved. One of our problems is to give the people of our State the very best available medical and surgical care at a reasonable cost. The State of Michigan conferred special rights and privileges upon us when it gave us a license to practice the art and science of medicine. These rights and privileges carry very definite responsibilities which we, as doctors of medicine, must assume. One of the many functions of the State Medical Society is to aid our doctors in carrying out these responsibilities.

I accept the Presidency of the Michigan State Medical Society with deep humility, and pray for Divine Guidance to perform my duties faithfully, and to serve this Society to the best of my ability.

It is my good fortune to know all the living Past Presidents of this Society, most of them rather intimately. When I review the things that these men have done for us, without regard for cost in time or work, it gives me a feeling of inadequacy. During the next twelve months I shall take the liberty of calling on these men for advice and guidance.

Since graduating from medical school, two very wonderful honors have been bestowed upon me, and both have to do with the State of Michigan, the greatest State in the Union. First, just forty years ago the dearest woman in the State of Michigan chose me to be her husband. And now the Michigan State Medical Society has made me its President, exactly forty years later. I love you both, and shall always be your willing and faithful servant.

What our Society accomplishes during the next twelve months depends upon having certain ideals and being able to translate those ideals into reality. By accepting committee appointments and working on them is the first step in that direction. I do hope that members of the Society who are willing to work, and who have knowledge of special problems, will offer their services.

We as medical men have dedicated ourselves to the service of mankind by rendering good medical and surgical care to all people in the State of Michigan at a reasonable cost, regardless of race, creed or color, letting the Golden Rule be the model for our conduct. We shall support our two medical schools and aid them in turning out more doctors of medicine. We would even welcome and support the establishment of another medical teaching facility to supply more doctors of medicine. Under no conditions will we condone sacrificing quality of teaching for quality of doctors. We adhere to the principle that a good doctor must be, first of all, a good citizen; and that medical care is such an intimate problem that it cannot be rendered by governmental agencies, corporations or hospitals.

Ladies and gentlemen, I believe in the private practice of medicine because it is the only system in which each individual has the right to choose his or her own doctor. Therefore, I ask you to join me in rededicating our lives to the service of our fellow men, to make available the very best medical care to all of our people, whether in cities or in rural areas.

I thank you for the honor that you have given me, and I shall do my best to deserve it.

* * *

THE SPEAKER: Dr. Jones' address will be referred to the Reference Committee on Officers' Reports.

IV. REPORTS OF THE COUNCIL

By William Bromme, M.D., Chairman

This begins to bring us down to the problems of the organization which attempts to serve you in maintaining the practice of medicine as we know it. This report is not the work of one person. This report is not the work of one committee. Rather, it is the work of about 600 doctors of our membership who have labored organization-wise on behalf of all of us, and tribute must be paid to all of our men who do work for all of us.

The annual report of The Council is published in the Handbook, which you have at hand, beginning on page 47, and with permission of the Speaker I will not read the text of that report.

1. *Membership.*—On September 1, 1955, the membership of the Michigan State Medical Society totaled 5,899. This compares very favorably with a total of 5,670 at the same time last year.

2. *Finances.*—(See accompanying report).

FINANCIAL REPORT FOR PERIOD ENDING AUGUST 31, 1955

ACCOUNT	On Hand 1/1/55	Income to 9/1/55	Expenses to 9/1/55	Balance on Hand 9/1/55
General Fund	$ 73,452.24	$130,449.11	$ 99,800.17	$104,101.18
Annual Session	.....	29,557.50	4,677.26	24,880.24
Michigan Clinical Institute	.....	12,746.00	14,382.50	- 1,636.50
THE JOURNAL	.....	55,553.43	45,327.36	10,226.07
Public Education	76,816.26	32,382.30	22,471.26	86,727.30
Public Service	3,330.00	18,063.51	16,437.13	4,956.38
Professional Relations	6,545.92	27,095.21	19,051.70	14,589.43
Public Education Reserve	30,000.00	.....	.....	30,000.00
Rheumatic Fever Control	13,645.55	21,025.00	10.765.28	23,905.27
Surplus from Dues	29,390.82	7,741.51	.....	37,132.33
Beaumont Memorial Fund	-10,480.29	200.00	.....	-10,280.29
Building Fund	11,770.04	10,322.00	4,164.84	17,927.20
TOTALS	$234,470.54	$345,135.57	$237,077.50	$342,528.61

3. *Michigan Medical Service.*—An up-to-date report on this corporation, including its finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 27, at 2 p.m. in

the Grand Ballroom of the Pantlind Hotel. All MSMS delegates are members of the Michigan Medical Service Corporation and are expected to attend this important annual meeting.

Michigan Medical Service proposed a new $6,000 family income service contract—study of adequate fee schedules therefor.

The 1955 contracts between labor and the automotive industry provide for prepaid medical-surgical care at a family income level of $6,000. It is estimated that 80 per cent of present subscribers to Michigan Medical Service will be eligible for such a program.

At the request of Michigan Medical Service, a committee composed of members of the Michigan State Medical Society, representative of each Councilor district, under the general chairmanship of L. W. Hull, M.D., Past President, has been approved by The Council, has held one organizational meeting, and has gone seriously to work.

Every member of the Michigan State Medical Society will receive a questionnaire asking him to indicate what he believes is a fair and just professional fee for the services indicated. It is the hope that every member of the Michigan State Medical Society will respond with information which can be utilized in the development of this new fee schedule. This is a real challenge for all of us because the community service provided by Michigan Medical Service has been good for all concerned, and because we know that many closed panel groups in labor, industry, government and otherwise would like to control the providing of this service. It has been the conviction of the Michigan State Medical Society that the medical profession must control this service.

4. *Beaumont Memorial.*—Otto O. Beck, M.D., Birmingham, Chairman of the Beaumont Memorial Committee, presented the following financial status of the Beaumont Memorial to The Council yesterday:

Subscribed to September 1, 1955	$35,593.30
Expended to September 1, 1955	45,873.59
Advanced by MSMS	10,280.29

The Council invites additional donations to the Beaumont Fund so that the expenses of building and furnishing the Memorial may be fully liquidated through voluntary means.

The Beaumont Memorial continues to be one of the finest public relations projects ever achieved by the medical profession of Michigan. It is a perpetual reminder to the people of Michigan and the nation of the many and enduring scientific contributions made by Michigan's doctors of medicine in their behalf.

5. *Michigan's Foremost Family Physician for 1955.*—Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is the privilege of the House of Delegates. According to the established procedure, the field of nominees has been narrowed to three, from which the House of Delegates has the privilege of electing one.

The three nominees are:

Paul W. Rigterink, M.D., Grand Rapids
Paul Van Riper, M.D., Champion
Walter H. Winchester, M.D., Flint

6. *List of Nonmembers.*—Pursuant to the House of Delegates' instruction of 1948, The Council (through Secretary L. Fernald Foster, M.D.) today submits a list of former members whose 1955 MSMS dues were not paid as of September 1, 1955. To insure accuracy, this list recently was submitted to and certified as correct by our component county and district medical society secretaries.

7. *MSMS Health and Accident Insurance Program.*—The report to September 15, 1955, supplied by the carrier (Provident Life and Accident Insurance Company of Chattanooga, Tennessee), is as follows:

Premiums Collected	$396,420.88
Premiums Earned	336,907.02
Claims Paid	150,441.09
Reserves on Claims Reported and in Process of Payment	39,646.43
Reserves on Claims Incurred but Unreported	15,895.47
Total Claims Paid and Claim Reserves	205,982.99
Loss Ratio on Earned and Incurred Basis	61.14 per cent

8. *Grand Award to Michigan State Medical Society.*—The American Trade Association Executives, at its 1955 convention at Mackinac Island, presented to the Michigan State Medical Society a plaque indicating the Grand Award, covering state associations of all kinds throughout the nation, for the eminently successful program of your State Society in recruiting and training of medical associates. ATAE, in presenting the plaque to the MSMS Council Chairman, indicated that "the impact of this medical associates campaign has highlighted this contemporary career opportunity throughout the nation."

9. *"You Are Organized Medicine's Basic Unit"* is the theme of the 1956 Annual County Secretaries-Public Relations Seminar. This forthcoming program has been expanded from a one-day into a three-day seminar, scheduled for January 27-29, 1956. It will include general assembly, classroom and other modern techniques of communication and audience participation. The program is beamed at enlightening medical leaders, elected to office on the county level, concerning the opportunities of organized medicine in combatting the four basic threats to health welfare. Every member of the House of Delegates is most cordially invited to attend this meeting in Detroit, January 27-29, 1956. This three-day seminar is built around and for *you*, as organized medicine's basic unit.

10. *Contacts With Governmental Agencies.*—(a) Liaison Committee with State's Executive Office. The Council is pleased to announce that Governor G. Mennen Williams has accepted the formation of a liaison committee to the State Executive Office, to be available when questions of a medical nature are referred by the Governor to the Michigan State Medical Society. The personnel of this committee is: Robert H. Baker, M.D., Pontiac; Milton A. Darling, M.D., Detroit; L. Fernald Foster, M.D., Bay City; Kenneth H. Johnson, M.D., Lansing; William S. Jones, M.D., Menominee, and Ralph W. Shook, M.D., Kalamazoo.

(b) E. C. Swanson, M.D., Vassar, was elected by his nine confreres of the Michigan State Board of Registration in Medicine as Secretary of that State agency on September 2, to succeed J. Earl McIntyre, M.D., Lansing, retired.

The Council congratulates Dr. Swanson and offers him the wholehearted co-operation and assistance of the Michigan State Medical Society in his important work.

11. *Standards of Membership.*—Just before the 1954 House of Delegates' annual session, a committee of The Council was appointed (composed of three Past Presidents) to survey the MSMS Bylaws concerning the standards of membership and the disciplining of members. During the past year this committee has given serious study to the problems of mediation, grievance and ethics, and from time to time has submitted its opinions to The Council for confirmation. This study is one of many complexities, further involved by geographic and other variations from the norm. It will take this committee additional time to complete its study and present to the House of Delegates its final recommendaions for correcting present inconsistencies.

Further study having been given to these problems,

the Mediation, Ethics and Grievance Committee, at its September 25 meeting, agreed in principle as to the distinction between the function of mediation committees and ethics committees. It was agreed that mediation committees shall act as friendly intermediaries by consent of the disputing parties, without power to arbitrate or compel agreement or to exact discipline. Ethics committees concern themselves with infractions of proper professional behavior, and treat with the relationship of a society member to his fellow members, to his society and to his profession, and with the power to recommend discipline for infraction of proper professional conduct.

Consideration has been given to those things which will constitute infractions of ethical practice of medicine and further study to develop necessary mechanics of operation, and any necessary revisions of the MSMS Bylaws will be prepared for presentation as soon as possible to the MSMS House of Delegates. It is expected that specific recommendations of revisions to the Bylaws will be ready for presentation to the 1956 House of Delegates.

12. *Invitations to all New Practitioners.*—As instituted last year, all doctors of medicine who entered practice in Michigan since the last MSMS Annual Session recently were sent special invitations to attend the 1955 convention. In this list of over 300, nonmembers as well as members were included. The Annual Session should indicate to nonmembers some of the many values of association with the Michigan State Medical Society, one of the most progressive state medical units in the United States.

13. *MSMS Public Relations Manual, "Winning Friends for Medicine."*—Two additional projects are being developed for inclusion in "Winning Friends for Medicine," the MSMS public relations guide book for county medical societies which is the basis for our co-ordinated medical public relations program in Michigan for the second year. One project will suggest means of county medical society co-operation with the various health programs sponsored locally by fraternal organizations and service clubs. The other will outline public relations aspects of medical society guidance in local school health programs and activities, based on the policies developed by the Michigan State Medical Society Child Welfare Committee and the pioneering experience of the Wayne County Medical Society.

14. *Annual Reports of Committees.*—

(a) Supplemental Report by Liaison Committee with Michigan Medical Service:

At our July 16 meeting one component county society submitted a complaint received from a veterans' organization re medical care of veterans. This committee recommended that the complaint be investigated and handled on the county medical society level.

The revised forms of medical reports to veterans' facilities, drawn up by Michigan Medical Service, were given study and approval by this Committee.

(b) Special Committee (of The Council) on Resolution re Joint Commission on Accreditation. This Committee, at its August 24 meeting, adopted the following policy statement:

We recognize the need for accreditation of hospitals if the highest standards of patient care are to be maintained. We remind ourselves that the collective effort known as the Joint Commission on Accreditation was entered into voluntarily to avoid the possible pitfalls of unaided nonprofessional control of accreditation.

We believe that every effort should be made to maintain our present representation in this Joint Commission and to preserve the ideals they have thus far evolved.

However, we feel that a careful study should now be made to assess and possibly improve the practical application of the principles of accreditation.

To this end, the Michigan State Medical Society has made a study of grass roots level complaints in this State, and offers the following suggestions as requested by the Committee on Review of the AMA:

(1) We recommend that inspectors examining hospitals in the name of the Joint Commission sever all connections with the parent organization making up the Joint Commission, and become exclusive employes of the Joint Commission.

(2) We recommend that the Joint Commission undertake to train its inspectors as to methods and attitudes of applying the principles set forth by the Joint Commission, uniformly.

(3) Many doctors are disturbed over the amount of time required for the review of the conduct of the practice of medicine through the records of accredited hospitals, to the detriment of the teaching program and patient care. Therefore, we ask the Joint Commission to clarify its position as to the mechanics and detail required in case and statistical review toward an objective of simplification.

(4) We request the AMA Committee on Review to investigate the allegation that open staff hospitals are categorically down-graded under the accrediting system now in effect.

(5) Many hospital staffs and county medical societies are disturbed over the undue emphasis being placed by inspectors on the need for outpatient clinic facilities, and we question whether the services of an outpatient clinic are essential to an intern training program. Basically, we believe that the policy underlying the establishment of outpatient departments should be determined by the local county medical society.

(6) We recommend that all directives and interpretations of the Joint Commission which alter the Standards for Hospital Accreditation and are pertinent to the practice of medicine be officially communicated directly to the chiefs of staff of all hospitals, as well as to hospital administrators, promptly.

(c) The Council respectfully invites attention to the critical status of the General Fund of the Society. It reminds the House of Delegates that the dues of the Michigan State Medical Society have not been increased since 1950.

No material increase except for assessments since 1944, in which year there was a $10 assessment; the following year, 1945, this was increased to $15, and in 1946 the assessment was raised to $25 and continued at $25 until the 1950 House of Delegates, for tax purposes, made the assessment a part of the dues and voted an increase of $8 per year per member, to bring the total to $45, which has continued until this date.

Due to a marked increase during the last few years in the General Fund activity and coincident expenditures, including greatly augmented committee work, necessary salary increases to meet rising costs of living, and a retirement program to encourage more permanent tenure of employment, The Council found it necessary to borrow $5 per member in 1955 from the Public Relations allocation to bolster the weakened General Fund. Because of the foregoing—and a continuation of this unhealthy situation into the unforeseeable future—The Council recommended at its meeting yesterday that the dues of the Michigan State Medical Society be increased. A recommendation on this subject follows.

15. *Michigan State Medical Assistants Society.*—This young organization continued to expand during the year, both in membership and in service to the medical profession, to local medical societies, and to the communities in which chapters are situated. MSMAS now has more than 650 active members, of which 200 are new within the past year. Five new chapters (in Jackson, Van Buren, Calhoun, Oakland and Barry Counties) were organized during the year, bringing the total to sixteen. The current President has attempted to visit

each component society during her term in office. The 1954 MSMAS annual meeting in Detroit drew a total registration of 371.

One major goal achieved during the year, through the co-operation and counsel of MSMAS (with assistance from MSMS), was the two-year course for medical assistants, which will be initiated in September at Ferris Institute, Big Rapids. In addition to the variety of adult education programs and other community projects at the local level, MSMAS representatives participated in the Sixth Annual Michigan Cancer Conference, the annual meeting of the Michigan Health Council, planning sessions of the Michigan Rural Health Conference, a panel discussion on Medical Health Education at the annual MSMS County Secretaries-Public Relations Conference, and in an advisory capacity at the annual meeting of the Kansas Medical Assistants Society. Michigan continues to hold its lead in organization of medical assistants.

16. *Matters Referred to the Council by the House of Delegates.*—

(a) Uniform Health Insurance Claim Forms: Referred by the 1952 House of Delegates. A two-year co-operative effort by the insurance business and the American Medical Association to streamline health insurance claim forms used by doctors of medicine is nearing a successful conclusion. The Health Insurance Council's Special Committee on Uniform Claim Forms has submitted for acceptance by insurance companies the final drafts of two all-purpose and two abbreviated physician statement forms. One all-purpose and one abbreviated form are for use with group insurance policies, and the other two are for individual and family policies. Substantial company support for these four forms is indicated by the responses received to date from the companies, according to the Health Insurance Council.

Two other short forms already have received approval from the AMA's Council on Medical Service and have been accepted by companies writing the majority of the commercial health insurance business in America. One of these approved and accepted forms covers physicians' statements in connection with group surgical benefits, and the other form covers individual or family hospital, medical or surgical benefits.

Around the end of 1955 The Council plans to have ready for wide distribution throughout the medical profession a pamphlet which will tell the story of the uniform claim forms project, and will also serve as a working guide on the use of new uniform and streamlined claim forms. (See addendum)

(b) Involved reports of Michigan Social Welfare Department: As reported last September, this action of the 1953 House of Delegates was invited to the attention of the Michigan Social Welfare Commission, which recomemnded that MSMS appoint a committee to work with the Commission's Medical Advisory Committee to find a solution to the problem. The MSMS committee is composed of W. B. Harm, M.D., Detroit, Chairman; O. J. Johnson, M.D., Bay City, and C. A. Paukstis, M.D., Ludington. The minutes of your committee, which met with the Commission's Medical Advisory Committee on January 14, 1955, are attached as an addendum.

(c) Greater Uniformity by Basic Science Boards: A supplemental report recently was submitted by the Committee on Study of Basic Science Act. (See addendum)

(d) Assistants' Fees under Michigan Medical Service: The 1954 House of Delegates recommended to Michigan Medical Service "That it develop procedures to pay surgical fees to the operating surgeon and the assisting physician who has actually and in person assisted at the surgical operation on the patient when and if requested by the operating physician."

The Special Committee of the Board of Directors of Michigan Medical Service has this complex matter under consideration. One report to its Board of Directors was not adopted by the Board, and the matter was referred back to the Committee for further consideration.

(e) Migrant Workers: A final report from E. F. Sladek, M.D., Traverse City, member of the Governor's Commission on Migrant Workers, was submitted to The Council on August 18, and is attached as an addendum to this report. In a word, the problem of procuring health service for migratory workers has *not* been solved. Dr. Sladek's efforts have been diligent, but often frustrating to him. The problem remains with us—an annual irritant that challenges the medical profession of this State to seek a solution before some catastrophe (such as an epidemic) hits some section of this State. (See addendum)

(f) Deans' Panel—Time Change: Your attention is respectfully invited to a time change in the Panel on Undergraduate Medical Education, approved by your Speaker and Vice Speaker. This panel will not be held at luncheon on this date, Monday, September 26, but will be held today in this room at 4 p.m.

17. *Death of Stuart A. Campbell.*—The Council announces with deep regret the passing of Stuart A. Campbell, Field Secretary of the Michigan State Medical Society for the past six years. Mr. Campbell died on July 16 after an illness of over a month. The Michigan State Medical Society has lost an ardent and enthusiastic worker in "Scotty" Campbell, a man admired and loved by many of our members throughout the State.

Mr. Speaker, may we have your permission to pause for one moment in our report, as you may wish at this time to request the House to stand in memory of Stuart A. Campbell.

(Silent, standing tribute to Mr. Campbell.)

Recommendations

The four recommendations coming from the annual report of The Council, published on page 47 in the Handbook, are as follows:

(1) That The Council be authorized to send MSMS representatives to Washington, D. C. in 1956, on the occasion of the Annual Michigan Day.

(2) That contributions to the Beaumont Memorial Restoration Fund—by every individual MSMS member—be urgently recommended by the 1955 House of Delegates. Every member of the Michigan State Medical Society should take pride in contributing to the Beaumont Memorial, which will represent for generations the best type of public relations for the medical profession of this State.

(3) That each individual member of the MSMS House of Delegates pledge himself to further in his community or area the MSMS periodic health appraisal program, to the end that private medical practice will bring—in full measure to all people of this State—the life-lengthening health protections afforded by modern medical science. The doctor of medicine must keep in mind that this program is one desired by the people; and people usually secure what they demand—if not by voluntary means, then through compulsory legislation.

(4) That, in these times of change, The Council

trusts that it will continue to merit your continued support, co-operation and faith.

The Council, at its September 25 meeting, added two recommendations, as follows:

(5) That the policy statement of the Special Committee on Resolution re Joint Committee on Accreditation be adopted by the House of Delegates, and that a copy of this report be transmitted immediately to the American Medical Association Special Committee on Review of the Joint Committee on Accreditation.

(6) That the dues of the Michigan State Medical Society be increased $10 per member per annum, for allocation to the General Fund of the Society.

This report is respectfully submitted by The Council of the Michigan State Medical Society.

* * *

THE SPEAKER: This report will be referred to the Reference Committee on Reports of The Council, and will include reference of the annual report of The Council as printed beginning on page 47 of your Handbook.

I thought you might be interested in seeing the plaque that Dr. Bromme mentioned. This is the plaque presented to us from the Michigan Legislature on Concurrent Resolution 34 regarding the Beaumont Memorial.

V. REPORT OF DELEGATES TO AMA

By W. A. Hyland, M.D.

The annual meeting of the American Medical Association for 1955 was held on June 6 to June 10 in Atlantic City, with a total over-all registration of over 30,000, being one of the largest.

The House of Delegates' sessions were held on the 6th to 9th inclusive. Eighty resolutions were presented and studied.

Dr. Elmer Hess, the President-elect, assumed the Chair, with Dr. Dwight Murray, Chairman of the Council for several years, being unanimously named as his successor, and Dr. Millard Hill of North Carolina being elected Vice President. Dr. James Reuling, Speaker of the House, was named as Dr. Murray's successor on the Board of Trustees, with Dr. Vincent Askey of California being chosen as Speaker to succeed Dr. Reuling, and Dr. Louis Orr of Florida being named Vice Speaker.

The House of Delegates voted the 1955 Distinguished Service Award to Dr. Donald Balfour of Rochester, Minnesota. Dr. Balfour has been with the Mayo Clinic for nearly fifty years. At present he is Director of the Mayo Foundation for Medical Education and Research. Due to Dr. Balfour's illness, his son, Dr. William Balfour, accepted the Award for his father.

The clinical session for this year will be held in Boston the first week in December, and the 1956 annual meeting will be in Chicago next June.

The scientific sessions were held daily Monday through Friday, with emphasis being on cancer, mental health, poliomyelitis, geriatrics, cardiovascular disease, and the newer drugs.

The specialty groups evidenced more interest than usual on the economic problems facing them in addition to their scientific discussions. This was especially so of the Ophthalmologic Section, in which the majority felt that the former ruling of the Judicial Council prevented them from maintaining as close a relationship with their patients as they deemed necessary. Therefore, they voted to widen the scope of the Judicial ruling supported by the House of Delegates. From now on this will permit them to follow to completion, in their own offices if they so choose, the examination, prescribing and fitting of glasses. Dr. Haughey was very helpful in discussing this question.

In other phases the Board of Trustees was authorized to appoint a committee for continuing study of economics in its relation to medicine. This follows out the Pino resolution to have the American Medical Association keep abreast of the changing economic picture. They have increased the personnel of the executive offices at this time.

The suggestion of the ad hoc Committee on Intern Study, to not deny recognition to teaching hospitals unless they failed to obtain 25 per cent of their quota for two successive years, was passed. The former rule dropped hospitals if they failed to obtain 66⅔ per cent for two successive years.

The subject of accreditation of hospitals came up for considerable discussion. Many felt that the hospital groups in certain areas were usurping the medical profession's prerogative of being the predominant group to handle this question. Therefore, a resolution was passed, authorizing a special committee of the House of Delegates appointed to study and survey the work of the Committee on Accreditation and to return suggestions at the next session. The committee members were not to be those who are on the Joint Committee on Hospitals or Hospital Accreditation Committee at present.

A special committee to study medical practices, appointed some time ago, reported their findings in a 70-page report recently to the Board of Trustees. This group later on gave out certain portions of the report, but withheld the report as a whole, due to the fact that there was contained therein some critical material with direct quotes. The Board felt that there might be some partial use of the material by those who wish to criticize and put a different light on portions of the report.

Several members of the Committee felt that the report in its entirety should be made available to all the members of the House; therefore, Dr. DeTar moved that action on the report should be held over until the next meeting, and that in the meantime all members of the House were to receive this report for study. Dr. Murray, Chairman of the Board, stated it was not the intention of the Board to withhold knowledge from the members of the House, but rather that they felt it judicious not to publicize quoted material that might be construed adversely. Further, all members were welcome to read the report. As it would take some time to digest it, Dr. DeTar felt that further study and a subsequent report was the choice; therefore his motion was passed.

Director Draper of the United Mine Workers had designated his consulting group to pass on those who were to be admitted to this organization's hospitals. This method was disapproved by the House, with a recommendation of free choice of physicians in these cases. This action was unanimously passed.

The question of voluntary social security had been discussed by county and state groups, especially the younger men in many cases. The Michigan delegation with its executive officers felt that while the American Medical Association was against compulsory social security and successfully opposed it, they at no time disapproved the principle of allowing doctors of medicine to participate in federal social security on a voluntary and self-employed basis. Therefore, a bill was put in by us with the hope that the American Medical Association would at least discuss this situation more freely in the journals for the benefit of those who were interested.

The House disapproved of the American Medical Association asking for a recommendation to the Congress of the United States to change the present status of doctors of medicine in relation to social security, for fear that, once opening up the subject, it might weaken the American Medical Association's position on it, and also interfere with other legislation which they are now working on. But the House did recommend that the American Medical Association thoroughly discuss this subject in *The Journal* in the near future. The fact that something of an enlightening nature will be forthcoming satisfied us to a certain extent.

The subject that provided the most discussion was the osteopathic question. Dr. John Cline reported that after nearly a three-year study, his investigating committee, which visited five of the six osteopathic schools, found they were inferior to our medical schools, and needed help both didactically and financially.

It resolved into one of two things: Either suppress them legally, or elevate their standards by allowing doctors of medicine to teach in their schools. The resolution did not advocate recognizing osteopaths or osteopathy per se. After considerable discussion in committee, a majority and minority report reached the floor of the House. The minority report, which was adopted by the House of Delegates, said:

"One member of the Reference Committee was completely satisfied that an appreciable portion of current education in colleges of osteopathy definitely does constitute the teaching of 'cultist' healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice. Since he cannot with good conscience approve the recommendation that doctors of medicine teach in osteopathic colleges where 'cultism' is part of the curriculum, he respectfully makes the following recommendations to the House of Delegates:

"1. That the report of the Committee for the Study of Relations Between Osteopathy and Medicine be received and filed, and that the Committee be thanked for its diligent work and be discontinued.

"2. That if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges, and may approach the Trustees of the American Medical Association with a request for further discussion of the relations of osteopathy and medicine, then the said Trustees shall appoint another special committee for such discussion."

The majority report of the Reference Committee, which was rejected by the House, made the following recommendation:

"Your Reference Committee, after a study of the report of the Committee for the Study of Relations Between Osteopathy and Medicine and the study of other evidence submitted, is not completely satisfied that the current education in colleges of osteopathy is free of the teaching of 'cultist' healing.

"In view of the desire to elevate the standards of teaching in colleges of osteopathy, your Reference Committee recommends approval of the recommendation of the Committee that doctors of medicine may accept invitations to assist in osteopathic undergraduate and postgraduate medical education programs in those states in which such participation is not contrary to the announced policy of the respective county and state medical associations. Such teaching services would be ethical.

"Your Reference Committee approves the recommendation of the Committee that the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective states, or request their component county societies to do so.

"Your Reference Committee recommends that a committee be appointed at the discretion of the Board of Trustees, to confer with representatives of the American Osteopathic Association concerning common or interprofessional problems on the national level."

The minority report was adopted by a vote of 101 to 81.

It is quite evident we will hear more about this question in the future.

Among a large number of actions on a wide variety of subjects, the House of Delegates also:

Commended the "Medic" television program.

Reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization.

Approved the Headquarters Survey Report, which included the statement that "The only public relations program of any permanent value is the private and public relations of the individual doctor."

Expressed regret that the Hoover Commission saw fit to alter or eliminate some of the recommendations of its Medical Task Force.

Reaffirmed its opposition to extension of the doctor draft law.

Recommended the creation of an AMA Committee on Geriatrics.

Warned against the danger embodied in state legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

Each year the work of the House goes more intimately into all phases of scientific and economic medicine, which is a very healthy state for the American Medical Association.

In carrying out some of the ideas suggested in the Pino resolution from this House of a year ago, a public relations firm has been employed to aid the American Medical Association's relations with the public and keep abreast of many of the political implications in actions of the Senate and Congress. Further, the Legal Department has been expanded and individualized, this in order to at all times keep the organization within its privileges of the federal laws, rather than to suddenly have the power that be of the government descend on us with a summons to answer for actions innocently taken but outside of the interpretation of the law as related to the organization.

Each day your delegates, alternates, officers, legal adviser and members of our Society who happened to be attending the meeting met at breakfast and discussed various economic phases of the session. Some of the leading figures in medicine, who were acquainted with pertinent subjects of the session, joined in and freely discussed with us their opinions, which in all cases proved very helpful.

We were honored also by the President of the Pakistan Medical Association, who is very positive that world peace will come through the leadership of the physicians in all countries. He believes that our common ground in caring for health brings our profession closer than other groups, and our honest discussions of medical subjects will convince all peoples of our sincerity, and that after this trustful attitude is established rapid progress toward world health and peace will be well started. He really convinced me.

This thought was given further impetus by the head of one of the leading military academies of this country, General Milton Baker, Commander of Valley Forge Military Academy, at a medical meeting in the East within the last ten days, when he stated, "The doctor's satchel has a world peace role, as it can reach into places where the diplomat's briefcase is powerless."

Respectfully submitted by the Michigan Delegates to the American Medical Association:

W. A. Hyland, M.D., *Chairman*
W. D. Barrett, M.D.
J. S. DeTar, M.D.
W. H. Huron, M.D.
R. A. Johnson, M.D.
R. L. Novy, M.D.

Dr. Hyland: Dr. Grover Penberthy, Chairman of the Surgical Division, must be included in this group, due to his intense interest and wise counsel at all times. He is a father councilor to all of us. Next year, in addition, we will have with us Dr. Arnold of Hawaii.

The Chairman wishes to express his personal appreciation to the delegates from Michigan: W. D. Barrett, M.D.; J. S. DeTar, M.D.; W. H. Huron, M.D.; R. A. Johnson, M.D., and R. L. Novy, M.D.

To the alternate delegates: W. W. Babcock, M.D.; O. J. Johnson, M.D.; C. I. Owen, M.D.; E. F. Sladek, M.D.; J. R. Rodger, M.D., and G. W. Slagle, M.D.

To the officers: R. H. Baker, M.D., President; W. S. Jones, M.D., President-elect; William Bromme, M.D., Chairman of The Council; L. Fernald Foster, M.D., Secretary; Wilfrid Haughey, M.D., Editor; William J. Burns, LL.B, Executive Director, and J. Joseph Herbert, Legal Councilor.

To these and many others of the Michigan State Medical Society I wish to express my appreciation for their wise counsel and advice; also the delegates and alternates through me wish to express appreciation to you, the members of the House of Delegates, for allowing us to represent your views in the parent organization, the American Medical Association.

The following is an editorial from the August 20, 1955, issue of the *Journal of the American Medical Association,* entitled, "Progress on Jenkins-Keogh Bills," and it reads as follows:

"On July 19 the Committee on Ways and Means of the House of Representatives, by a vote of 16 to 8, included an amended version of the Jenkins-Keogh bills in the 'bobtail' revenue bill. In the hectic last days of the first session of the 84th Congress, Chairman Jere Cooper (D., Tenn.) officialy killed this catch-all revenue bill for this year, and stated that the Committee will try to complete the bill after Congress reconvenes next January.

"This favorable Committee vote in July is the high water-mark in the long struggle to obtain tax deferment equality for the self employed and the pensionless employed.

"During the hearings on the Jenkins-Keogh bills on June 27 and 28, eight Congressmen who are not members of the House Ways and Means Committee testified in favor of the principle of these bills. (The testimony presented by the American Bar Association, American Dental Association, American Farm Bureau Federation, American Medical Association, and the statement and analytical report on the bills by the Treasury Department have been published in Bulletin 100 by and may be obtained from the AMA Bureau of Medical Economic Research.)

"The Secretary of the Treasury three times granted that the federal revenue laws are unfair to the self-employed and strongly urged that the bills, if approved, exclude the pensionless employed in order to reduce the revenue loss. The bill was so amended.

"Other changes were the reduction in the maximum amounts that could be excluded annually from $7,500 to $5,000 and in the lifetime maximum from $150,000 to $100,000.

"Other amendments would permit combinations of an annuity contract with a life insurance policy, with tax deferment only on the annuity part of the premium, and the use of a bank as a custodian of retirement funds.

"These four amendments were made before the 16 to 8 vote was taken. The failure of the Ways and Means Committee to report out the 'bobtail' tax bill before adjournment in August means that the amended Jenkins-Keogh bills cannot be acted upon in the House until the Committee approves the completed 'bobtail' bill after Congress reconvenes next January. The possibility that the Committee will not complete the 'bobtail' bill during the next session, or will report it out with the amended Jenkins-Keogh bills omitted, now seems remote.

"The progress made during this first session of the 84th Congress, and the strong statements made by many members of Congress during the hearings of June 27 and 28, should encourage physicians, other self-employed persons, and other interested individuals to inform their congressmen of their views while they are at home this fall. The prospects for the enactment of these bipartisan bills to establish a voluntary pension system for the self-employed are definitely on the upgrade. Perhaps the time is approaching when it will no longer be an economic sin to be self employed."

* * *

THE SPEAKER: The report of our delegates, as given by Dr. Hyland, will be referred to the Reference Committee on Officers' Reports.

VI. REPORT OF WOMAN'S AUXILIARY TO MSMS

By Mrs. A. F. Milford, President

No written report was presented to the House of Delegates. Mrs. Milford's "off-the-cuff" talk was a general review of the activities of the Woman's Auxiliary to the Michigan State Medical Society during the past year.

THE SPEAKER: This report will be referred to the Reference Committee on Officers' Reports.

ATAE Grand Award Won by MSMS

Before we call for the next item on the agenda, I would like to remind you of what Dr. Bromme told you about the award given the Michigan State Medical Society by the American Trade Association Executives for the project of promoting medical assistants.

I would like to show it to you. It is a very lovely thing. It will look nice in 606 Townsend. It is signed by A. Boyd Campbell, President of the Chamber of Commerce of the United States, Henry G. Riter, President of the National Association of Manufacturers, Richard L. Rozelka, Dean of the School of Business Administration, University of Minnesota, and Dr. Russell A. Stevenson, Dean of Business Administration, University of Michigan.

VII. REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

By Mrs. Charlotte Ash, President

The medical assistants are happy to be at your State meeting, and we have planned a very full and interesting program.

We know that the Michigan State Medical Society has been a leader in progressive steps in the medical field, and we hope that bringing in our group of medical assistants is another one of those steps in which Michigan medicine is leading.

There is a total of sixteen component societies in Michigan, six having been formed this past year, with a total membership of 695. On the State level we have participated in the panel discussion on medical health education and the Secretaries' Conference. On the county level, meetings are held monthly, with programs consisting of lectures, demonstrations in office technique, meeting the public, and various phases of medical services in which we take part.

Several societies have sponsored adult educational courses and have Placement Bureaus in aiding the doctors to find competent help. We feel that this has made our work of more value to you, and we hope it will help us bring back to the medical profession some of the esteem which the family doctor of yesterday enjoyed. In turn, we hope that you will continue to make it possible for the girls who work in your offices to take part in this program. Allow them the time necessary to carry on the work, and encourage their participation. We feel it will pay dividends to you, to us, and to the public we serve.

We want to thank you for the "You Are Eligible" pamphlets you had printed for us. They are very attractive and very much in demand.

Our meeting is being held on Wednesday and Thursday of this week at the Manger Rowe Hotel. We would be honored to have you attend any of our lectures that would be of interest to you.

Thank you for including us in your program.

* * *

THE SPEAKER: This report will be referred to the Reference Committee on Officers' Reports.

VIII. SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

(Vice Speaker K. H. Johnson, M.D., assumed the Chair.)

As you know, it is the privilege of this group to select Michigan's Foremost Family Physician for an award. The names are presented by whichever county medical society wishes to submit a name. The County Society's Committee of The Council goes over the names and presents them to The Council. The Council then narrows the field down to three, and Dr. Bromme presented to you the names of the three men who will be voted upon at this time.

They are: John W. Rigterink, M.D., Grand Rapids, presented by Kent County. Paul Van Riper, M.D., Champion, presented by Marquette-Alger County. Walter H. Winchester, M.D., Flint, presented by Genesee County. Our Secretary will now present biographical data on these three nominees which will help you judge.

(Subsequently the Chair announced that Walter H. Winchester, M.D., Flint, had been chosen for this honor.)

We will reconvene promptly at 2 p.m.

(The meeting recessed at 12:15 p.m.)

MONDAY AFTERNOON SESSION

September 26, 1955

The meeting reconvened at 2:10 p.m., Dr. J. E. Livesay, M.D., Speaker of the House, presiding.

IX. RESOLUTIONS AND MOTIONS

IX—1. RESOLUTION RE PERIODIC HEALTH EXAMINATIONS BY HOSPITAL STAFFS

O. B. MCGILLICUDDY, M.D. (Ingham): This is a resolution dealing with the resolution that was referred last year by the House of Delegates to The Council. The Council appointed a study committee. The study committee's report will be made available to the Reference Committee.

"Whereas, certain organizations demand periodic examination of certain of their members, and

"Whereas, certain hospital staffs have been organized to conduct these examinations, and

"Whereas, there arises the question of interference with the patient-physician relationship which represents the basic philosophy of the best method of medical practice, and

"Whereas, such examinations take hospital beds away from sick people and may make it necessary to build hospitals for examination purposes rather than for care of the sick; therefore, be it

"RESOLVED: That county medical societies and hospitals in various communities in the State should be requested to send in reports on how the problem has been handled in their localities; and be it further

"RESOLVED: That each participating physician, who is not regularly employed by the hospital, render his own bill and make sure that it is clearly identified in any complete bill rendered; and be it further

"RESOLVED: That the major part of these examinations be conducted in the doctors' offices or outpatient departments in order to conserve beds for the sick; and be it further

"RESOLVED: That the hospital medical staffs choose the physicians for these examinations by rotation from all those qualified to conduct such examinations; and be it further

"RESOLVED: That while hospital medical staffs may agree on a local solution to this problem, each hospital staff must not lose sight of the physician-patient relationship, which is primarily the concern of the county medical society as a unit."

THE SPEAKER: The Chair will refer this resolution to the Reference Committee on Legislation and Public Relations.

IX—2. RESOLUTION RE APPRECIATION OF PUBLIC SERVICE RENDERED BY R. L. NOVY, M. D.

M. A. DARLING, M.D. (Wayne):

"Whereas, Robert L. Novy, M.D., during his thirteen years as President of the Michigan Medical Service, has rendered inestimable service to that organization, to the Michigan State Medical Society and to the physicians and people of the State of Michigan, and

"Whereas, this has been a difficult period of reorganization followed by remarkable expansion, and

"Whereas, he has rendered this service entirely without compensation; therefore, be it

"RESOLVED: That the Michigan State Medical Society express its great appreciation of these valued services by having this resolution suitably inscribed on a scroll and presented to Dr. Novy."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

C. W. COLWELL, M.D. (Genesee): Mr. Speaker, with the permission of the gentleman introducing the previous resolution, I would like to add the following addendum from Genesee County:

"Whereas, we have in our County the second largest number of subscribers to Blue Cross-Blue Shield of any county in the State, and we therefore realize the immense importance of the advances made under Dr. Novy's able guidance. Although differing in many concepts, we nevertheless have always been in favor of prepaid medical insurance. We in Genesee County are very happy to have the opportunity to honor this gentleman, and respect him for the most excellent job that he has performed."

THE SPEAKER: The resolution and the addendum will be referred to the Reference Committee on Resolutions.

IX—3. RESOLUTION RE THE BEAUMONT MEMORIAL PRESERVATION

A. B. GWINN, M.D.:

"Whereas, in Senate Concurrent Resolution No. 34, adopted by both Houses of the Legislature on March 17, 1955, the Michigan Legislature expressed its interest in the Beaumont Memorial on Mackinac Island and recognized the contribution of numerous members of the Michigan State Medical Society in restoring this historic site; and,

"Whereas, the medical doctors of the Michigan State Medical Society sincerely appreciate this compliment, and share with the Legislature and citizens of Michigan a great pride in Mackinac Island State Park as one of our nation's most historic spots, and

"Whereas, the Mackinac Island State Park is a tourist mecca that, with proper encouragement, will become increasingly popular as an historic area of interest and inspiration to all who visit it, and

"Whereas, the Michigan State Medical Society, in organizing a campaign for private voluntary contribu-

tions from its members to finance restoration of the building which is now Beaumont Memorial, has initiated an idea which could greatly benefit the future historic development of the Mackinac Island State Park by the utilization of funds from sources other than the appropriation of public moneys, and

"Whereas, the members of the Michigan State Medical Society maintain a continuing interest in the Beaumont Memorial as their own project in the total development of the Mackinac Island State Park, this being evidenced by the further provision of interior furnishings and special historical exhibits for the Beaumont Memorial after its conveyance to the people of Michigan in dedication ceremonies on July 17, 1954; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society express its deep appreciation to the Michigan Legislature for its complimentary action in adopting Senate Concurrent Resolution No. 34; and be it further

"RESOLVED: That in the interest of preservation of the Beaumont Memorial and its future expansion as an historic shrine, the Michigan State Medical Society respectfully urges the Michigan Legislature to (a) continue its interest in the Beaumont Memorial, and (b) in order to better meet this purpose, to authorize an Advisory Committee of the Michigan State Medical Society to confer each year (or more often, as necessary) with the Mackinac Island State Park Commission as an advisory group on the maintenance and improvement of the Beaumont Memorial; and be it further

"RESOLVED: That the Michigan State Medical Society respectfully and urgently suggests that the Michigan Legislature at its earliest convenience study and put into action a program which would encourage other professional groups, trade associations, and civic and historical organizations to adopt projects supported by voluntary financial contributions for restoring and renovating the many other historical sites in the Mackinac Island State Park as a reminder of the remarkable part Michigan has played in many fields of American scientific, cultural and political progress."

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

IX—4. RESOLUTION RE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

J. M. WELLMAN, M.D. (Ingham):

"RESOLVED: That the House of Delegates of the Michigan State Medical Society instruct its delegates to the House of Delegates of the American Medical Association to ask for a review of the actions and recommendations of the Joint Commission on Accreditation of Hospitals by a committee the majority of which shall be selected from doctors of medicine actively engaged in private practice."

THE SPEAKER: This will be referred to the Reference Committee on Reports of The Council which already has this subject on its agenda.

IX—5. RESOLUTION RE THE SCREENING OF FOREIGN INTERNS

A. E. SCHILLER, M.D. (Wayne):

"Whereas, this problem concerns hospitals, educational programs, the physicians and the people in Michigan, and

"Whereas, it has long been an established fact that there are almost double the number of approved internships in this country as there are American graduates to fill the available places, and

"Whereas, the use of foreign graduates has fulfilled this need as well as encouraged the 'Good Neighbor' policy established by the State Department, and

"Whereas, a list of acceptable foreign medical schools has been prepared by the Council on Medical Education and Hospitals of the American Medical Association and the Executive Council of the Association of American Medical Colleges, and

"Whereas, in Michigan the State Board of Registration, its then Secretary, has ruled that all foreign graduates must be screened by it prior to appointment to internships, and

Whereas, although the hospitals wish to co-operate with the State Board of Registration in its efforts to maintain a strict supervision of all interns, it is their feeling that the 'cease and desist' order and the screening requirements of the State Department of the federal government and the hospitals were sufficient safeguards to prevent the flooding of the State of Michigan with foreign graduates insofar as these graduates must fully comply with the laws and regulations prior to licensure, and

"Whereas, the responsibility rests squarely on the hospitals and is knowingly assumed by them, and

"Whereas, these problems were presented to the State Board of Registration and signed by representatives of both the Wayne County Medical Society and the Detroit Area Hospital Council with the approval of the governing bodies of both organizations, and no explanation or action was forthcoming; therefore, be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society strongly recommend to the State Board of Registration a resumption of the previous methods of handling and admitting foreign graduates, or a modification of the present ruling which will permit a suitable time for these graduates to learn medical English before presenting themselves for examination."

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

IX—6. RESOLUTION RE APPRECIATION OF PUBLIC SERVICE OF R. L. NOVY, M.D.

D. W. THORUP, M.D. (Berrien):

"Whereas, Robert L. Novy, M.D., has served the medical profession of the State of Michigan in the capacity of President of Michigan Medical Service, and

"Whereas, this service has been rendered with intelligence, integrity and at considerable sacrifice, and

"Whereas, these services have been of inestimable value to the members of the Michigan State Medical Society and to doctors of medicine everywhere, and

"Whereas, Robert L. Novy, M.D., has submitted his resignation as President of Michigan Medical Service; therefore, be it

"RESOLVED: That the Berrien County Medical Society go on record as tendering to Robert L. Novy, M.D., their grateful appreciation of his service to the Michigan State Medical Society and to the medical profession of this country, and do formally request the adoption of this or similar resolution by the House of Delegates of the Michigan State Medical Sciety, and recommend that some suitable token of appreciation be presented to Robert L. Novy, M.D., by the Michigan State Medical Society."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

IX—7. RESOLUTION RE THE JENKINS-KEOGH BILL

J. M. MARKLEY, M.D. (Oakland):

"Whereas, physicians as a self-employed group have been discriminated against in the matter of an allowance for pension plans as a pretax offset against income tax, and

"Whereas, the Jenkins-Keogh bill now under consideration in Congress provides for a decent measure of correction of this inequity, and

"Whereas, by the merit of its being voluntary and capable of expansion to meet individual needs, the

Jenkins-Keogh bill is to be preferred over compulsory and self-vitiating social security; therefore, be it

"RESOLVED: That the Michigan State Medical Society support the Jenkins-Keogh bill; and be it further

"RESOLVED: That copies of this resolution be sent to all Congressmen and both U. S. Senators from the State of Michigan."

THE SPEAKER: I will refer this to the Reference Committee on Legislation and Public Relations.

IX—8. RESOLUTION RE MEDIC—COMMENDATION TO LOS ANGELES COUNTY MEDICAL SOCIETY

R. M. BRADLEY, M.D. (Genesee):

"Whereas, the weekly television production entitled 'The Medic' presents a realistic and dignified portrayal of recent progress in medical knowledge and techniques, enlightening millions of Americans on the role of today's doctor of medicine in modern society, and

"Whereas, 'The Medic' has cultivated public esteem for the medical profession as a whole, fostered the concept of private practice, gained favorable recognition of the philosophy of service held by the doctor of medicine, and widened appreciation for the discipline to which the ethical physician voluntarily complies, and

"Whereas, production of 'The Medic' would have been impossible without the co-operation and guidance of the Los Angeles County Medical Society, Los Angeles, California, and the many hours of technical assistance which individual members of that Society contribute week by week; therefore, be it

"RESOLVED: That the Michigan State Medical Society warmly commend the Los Angeles County Medical Society for outstanding service to both the American public and the medical profession through its co-sponsorship of 'The Medic,' and sincerely expresses the deepest gratitude of their Michigan colleagues to every member of the Los Angeles Society who has given his time and talent toward the success of that production."

THE SPEAKER: This will be referred to the Reference Committee on Miscellaneous Business.

IX—9. RESOLUTION RE MEDICAL REPRESENTATION ON VOICE OF AMERICA

W. W. BABCOCK, M.D. (Wayne):

"Whereas, health conditions in all other countries of the world affect the health of the people of Michigan, and

"Whereas, the practice of medicine in Michigan is influenced by methods of practice in nations other than the United States, and

"Whereas, the Voice of America can be a powerful influence to spread to all nations the health knowledge of American medicine and the advantages to patients and professions of the system of medical practice current in the United States today, and

"Whereas, expression of this health and medical information can be made best by representatives selected from the American medical profession; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates request the Michigan delegation to introduce and support in the next session of the American Medical Association House of Delegates a resolution calling for the American Medical Association to request the Voice of America to include upon its regular broadcasts the person and message of M.D. representatives of the American medical profession; and further be it

"RESOLVED: That the Board of Trustees of the American Medical Association be respectfully requested to defray the expenses and salaries involved in supplying personnel for the above purpose to the Voice of America."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—10. RESOLUTION RE PROPAGANDA ON SALK VACCINE

W. L. SHERMAN, M.D. (Wayne):

"Whereas, physicians who are responsible for all medical treatment have established standard procedures for the testing and release of all new drugs, and

"Whereas, one of the basic tenets for administration of treatment is the physician-patient relation, and

"Whereas, the physicians in Wayne County and the Detroit Department of Health have effectively applied this principle for twenty-eight years to preventive as well as curative medicine, and

"Whereas, the National Foundation for Infantile Paralysis, Inc., a lay organization, released the Salk polio vaccine, a medical treatment, to the public on a promotional basis and arbitrarily ruled that the polio vaccine could only be given in group clinics; therefore, be it

"RESOLVED: That the Michigan State Medical Society express its objections to the National Polio Foundation for its violation of basic medical procedures and principles; and be it further

"RESOLVED: That a special committee be appointed to determine the positions of physicians should such encroachments by a lay organization occur in the future."

THE SPEAKER: I will refer that to the Reference Committee on Hygiene and Public Health.

IX—11. RESOLUTION RE COUNTY SOCIETY MEMBERSHIP

N. F. GEHRINGER, M.D. (Oakland):

"Whereas, the Bylaws of the Michigan State Medical Society do not definitely state that a doctor of medicine is expected to become a member of the component society of the county in which his office is located, and

"Whereas, Chapter II, Section 3 of Bylaws of the Michigan State Medical Society, which provides for an exception, implies that a doctor of medicine is expected to hold his membership in the component society of the county in which his office is located, and

"Whereas, Chapter II, Section 3 of the Bylaws of the Michigan State Medical Society states that each component county society shall have general direction of the affairs of the profession in the county and shall exert its influence for bettering the scientific, moral and material conditions of every doctor of medicine in the county and

"Whereas, a component county society is unable to exert its influence to the fullest degree for the betterment of the practice of medicine in the county unless all eligible doctors of medicine practicing in the county are members, and

"Whereas, Chapter II, Section 3 of the Bylaws of the Michigan State Medical Society urges each component county society to increase its membership until it embraces every eligible doctor of medicine in the county, and

"Whereas, Chapter IV of the Bylaws of the Michigan State Medical Society provides for the transfer of membership from one component county society to another upon the change of location; therefore, be it

"RESOLVED: That Chapter II, Section 2 of the Bylaws of the Michigan State Medical Society be changed to read as follows: 'A doctor of medicine must hold his active membership in the component society of the county in which his office is located.'"

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

IX—12. RESOLUTION RE HOSPITAL PRIVILEGES

E. H. FENTON, M.D. (Wayne):

"Whereas, sufficient interest was manifested by the delegates at the last meeting of the American Medical Association in the state of tension caused by the disproportionate financial reward for surgical as opposed

to diagnostic and medical procedures, with its resultant encouragement of unethical procedures and unfavorable publicity, to demand that the full report of the Special Committee on Medical Practice be made available to them, and

"Whereas, our own delegates to the AMA can only act intelligently if they are made aware of our own feelings in the matter; be it therefore

"RESOLVED: That this body go on record as strongly urging that if the following program is not already satisfactorily put into operation, it be initiated immediately:

"1—That a subcommittee of the Medical Practice Committee be created to begin work on a relative value scale for the whole of the practice of medicine and surgery. Such a subcommittee could begin with the relative value scale produced by the thoracic surgeons (the only group which, as far as we can determine, has produced such a scale), and develop and broaden this approach, calling in as consultants representatives of general practice and all the specialties, as well as using the service of such nonmedical advisers as are needed.

"2—That a program of public education on the value of diagnostic and medical work be fostered by the AMA Public Relations Department to increase public appreciation of non-surgical work.

"3—That the AMA communicate to the specialty boards the findings of this survey, encouraging the boards to reappraise the value of their regulations restrictive on the practice of those seeking or holding board certificates during their early years of practice (with consideration of the removal of the restrictions in keeping with good medical practice). (Amended by Reference Committee. See Page 1512).

"4—And that the AMA continue to use its full influence to discourage the restrictions by hospitals against general practitioners as a group, regardless of their qualifications as individuals." (Amended by Reference Committee. See Page 1512).

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—13. RESOLUTION RE FLUORIDATION OF WATER

E. G. M. KRIEG, M.D. (Wayne):

"Whereas, the addition of fluoride compounds to the general water supply of communities leaves no freedom of choice to those who do not wish such treatment, and

"Whereas, the problem of tooth decay is best attended under the personal guidance of one's own dentist, and

"Whereas, this specific treatment can be easily administered to the individual by means of a prescription or treatment by his dentist; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend that the addition of fluoride compounds to the general water supply be discontinued in this State; and furthermore be it

"RESOLVED: That copies of this resolution be sent to His Honor, the Governor, the presidents of the state and county dental health societies, and the Commissioner of Public Health of the State of Michigan; and furthermore be it

"RESOLVED: That the intent of this resolution be called to the attention of our delegates to the American Medical Association, instructing them to present our feelings in this matter at their next meeting."

THE SPEAKER: I will refer that resolution to the Reference Committee on Hygiene and Public Health.

IX—14. RESOLUTION RE HOSPITAL FACILITIES FOR MENTALLY ILL

I. C. BERLIEN, M.D. (Wayne):

"Whereas, Michigan's facilities for the care of the mentally defectives are overtaxed and overcrowded, and long delays are being encountered in gaining admission to our State institutions, to the great detriment of the mental hygiene of the families involved, and

"Whereas, at the present time there are about 1,200 committed patients of young age and 'crib status' who are in urgent need of immediate medical care in hospital setting, and

"Whereas, there is also a great and ever-growing number of additional mentally defectives who likewise require training and medical care, and who are a hazard to the mental health (adjustment) of their immediate relatives; therefore, be it

"RESOLVED: That the Michigan State Medical Society recommend immediate definitive action by the Governor and Legislature of the State of Michigan to correct and prevent the recurrence of this deplorable condition." **(See Page 1509 for balance of resolution, amendment.)**

THE SPEAKER: That is referred to the Reference Committee on Legislation and Public Relations.

IX—15. RESOLUTION RE INCREASING PERSONNEL FOR THE MENTALLY ILL

R. W. TEED, M.D. (Washtenaw):

"Whereas, the State of Michigan continues to face an increasing number of problems in the field of mental health and

"Whereas, in past consideration of these problems many leaders in the State government have placed the greatest emphasis on construction and expansion of facilities to house the mentally retarded and the mentally ill, subordinating the fact that such facilities will be of limited value in meeting Michigan's mental health needs unless adequate personnel is available to staff these institutions, and

"Whereas, the Michigan State Medical Society believes—and has so recommended for the past several years—that any reasonable approach to Michigan's mental health problems must attach primary importance to programs for the training and recruitment of personnel skilled in the care, treatment and/or rehabilitation of the mentally ill and the mentally handicapped; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society respectfully calls upon the Michigan legislature to make State funds available to provide scholarships for doctors of medicine and nurses wishing to complete advanced study in psychiatric treatment and related fields, and for training other persons for careers associated with mental health; and be it further

"RESOLVED: That the qualifications for all such scholarships contain an agreement obligating the recipient to serve in Michigan's mental health system for a specified period commensurate with the value of the scholarship."

THE SPEAKER: That will be referred to the Reference Committee on Legislation and Public Relations.

IX—16. RESOLUTION RE OA & SI PROGRAM

R. W. TEED, M.D. (Washtenaw):

"Whereas, the membership of the Washtenaw County Medical Society believes that inclusion of physicians in the Old Age and Survivors Insurance program would bring financial advantages to these physicians and protection to their dependents, and

"Whereas, the House of Delegates of the American Medical Association has declared itself in opposition to the compulsory inclusion of physicians in the social security program, and

"Whereas, the prevalent opinion is that the government would not consider it feasible to include physicians on a voluntary basis; therefore, be it

"RESOLVED: That the Washtenaw County Medical Society go on record as favoring the inclusion of physicians under the Old Age and Survivors Insurance program; and be it further

"RESOLVED: That the Washtenaw Medical Society instruct its delegates to the House of Delegates of the Michigan State Medical Society to take action in the House leading to favorable consideration by the House of Delegates in this matter, and to the further instruction of its delegates to the House of Delegates of the American Medical Association; and be it further

"RESOLVED: That a copy of this resolution be forwarded to The Council of the Michigan State Medical Society and to the Board of Trustees of the American Medical Association, with the request that appropriate action with respect to Congress be taken; and be it further

"RESOLVED: That a copy of this resolution be forwarded to every county society in the State of Michigan, urging them to take similar action; and be it further

"RESOLVED: That the Michigan State Medical Society instruct its delegates to the House of Delegates of the American Medical Association to initiate action to poll the membership of the American Medical Association for an expression of their stand on social security for physicians."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—17. RESOLUTION RE FEE FOR EXAMINATION OF MENTALLY ILL

D. A. BOWMAN, M.D. (Bay-Arenac-Iosco):

"Whereas, the fee established by legislative enactment for the examination of mentally ill has not been increased in over twenty years, and

"Whereas, this makes it difficult for the Probate Court to obtain such examinations; therefore, be it

"RESOLVED: That the MSMS take steps to bring an increase in this fee."

THE SPEAKER: We will refer this to the Reference Committee on Legislation and Public Relations.

IX—18.—RESOLUTION RE POLLUTION OF INLAND WATERWAYS

H. F. FALLS, M.D. (Washtenaw):

"Whereas, the State Department of Conservation has, by purchase of waterfront land, opened up inland waterways and lakes and thereby made these waterways accessible to our citizens, including owners of large boats, and

"Whereas, pollution of Michigan inland waterways may therefore occur by insanitary disposal of human and other wastes; therefore, be it

"RESOLVED: That the Michigan State Medical Society urge the State Legislature to investigate this situation and take proper steps to eliminate any problem which may be disclosed."

THE SPEAKER: This is referred to the Reference Committee on Hygiene and Public Health.

IX—19. RESOLUTION RE POSSIBLE OPTOMETRIC LEGISLATION

H. F. FALLS, M.D. (Washtenaw):

"Whereas, an organized effort is being made to curtail the rights of the licensed physician, to wit, the attempt by the American Optometric Association to restrict visual care exclusively to the field of optometry, and

"Whereas, this same restriction is intended to apply to office aides, technical assistants and orthoptic technicians who aid the licensed physician in his office, and

"Whereas, such limitation would eventually result in inadequate service to the patient by the licensed physician, and

"Whereas, such unprecedented restriction of medical care by a lay group is a threat to all physicians; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society record their disapproval of such potential legislation in the State of Michigan; and be it further

"RESOLVED: That The Council of the Michigan State Medical Society be alerted to possible similar attempts by organized optometry, in order that a close perusal be made of all projected legislation; and be it further

"RESOLVED: That vigorous measures be authorized for informing the members of the State Legislature as to the intent of such legislation, in order that the rights of the patient to complete care and examination by the licensed physician will not be jeopardized; and be it further

"RESOLVED: That the Board of Trustees of the American Medical Association be informed immediately of action taken on this resolution."

THE SPEAKER: That will go to the Reference Committee on Resolutions.

IX—20. RESOLUTION RE ELECTION OF EXECUTIVE COMMITTEE OF THE COUNCIL

F. L. TROOST, M.D. (Ingham):

"Whereas, the House of Delegates of the Michigan State Medical Society is the policy-making and legislative body of the Society, and

"Whereas, it is recognized that The Council and the Executive Committee of The Council must act for the House of Delegates between sessions of the House of Delegates, and

"Whereas, the Executive Committee of The Council is composed of eleven members, only four of whom are directly elected by the House of Delegates, namely, the President, the President-elect, the Speaker and the Vice Speaker, and

"Whereas, the House of Delegates, being the policy-making body of the Society, should have the major voice in the selection of the Executive Committee of The Council; therefore, be it

"RESOLVED: That the Bylaws of the Michigan State Medical Society be amended as follows:

" 'At its annual session the House of Delegates shall elect from The Council five members to serve on the Executive Committee of The Council, the term of office being one year. From these five electees The Council shall choose a Chairman, a Vice Chairman, the Chairman of the Finance Committee, the Chairman of the County Societies Committee, and the Chairman of the Publication Committee'; and be it further

"RESOLVED: That Chapter VIII, Section 10(h) be added to the Bylaws to provide for the election of five Councilors to the Executive Committee of The Council by the House of Delegates; and be it further

"RESOLVED: That Chapter IX, Section 1 of the Bylaws be amended to provide that the Chairman of The Council, the Vice Chairman of The Council, the Chairman of the Finance Committee, the Chairman of the County Societies Committee, and the Chairman of the Publication Committee be elected by The Council from the five members of the Executive Committee of The Council elected by the House of Delegates."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

IX—21. RESOLUTION RE STUDY OF SURGICAL FEES (MMS)

H. W. HARRIS, M.D. (Ingham):

"Whereas, the Michigan Medical Service is the creation of the Michigan State Medical Society and of the physicians of Michigan, and

"Whereas, its continued growth and function requires, and indeed deserves, the full support and co-operation of all the physicians in the State, and

"Whereas, it is now proposed that coverage be expanded to a still higher income group of the people of the State of Michigan, and

"Whereas, the surgical fee schedule presently estab-

lished by the Michigan Medical Service is not realistic in many respects, and

"Whereas, this fee schedule is especially low for many operations usually done by the physicians in the so-called specialties groups, and

"Whereas, the fee in these fields is often not commensurate with the skill, time and effort required, as compared with other surgery of a more general, or frequent, or more publicized nature, and

"Whereas, this is particularly true in the operations not listed in the printed fee schedule; therefore, be it

"RESOLVED: That a committee, composed of a representative group of physicians of Michigan, including persons from the so-called surgical specialties, be appointed and directed to study the entire surgical fee schedule, with a view to correction of the above-mentioned, and any other inequities found in such study; and that this committee be directed to report its findings and recommendations to Dr. Hull's Committee on the Study of the Fee Schedules of the Michigan Medical Service, at a time to be determined by the Chairman of that Committee." (Amended by Reference Committee. See Page 1516.)

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

IX—22. RESOLUTION RE BLUE SHIELD REPORTING IN MEDIATION CASES TO COUNTY MEDICAL SOCIETIES

R. F. FENTON, M.D. (Wayne):

"Whereas, the county and state medical societies are charged with the responsibility of maintaining a high standard of integrity and ethics within our profession, and,

"Whereas, it is the moral duty of every member to report obvious violations of this Code, and

"Whereas, the Blue Shield organization has at the present time no adequate liaison with the various county medical societies in such matters, and

"Whereas, problems involving integrity are bound to arise between the Blue Shield organization and individual doctors of medicine; therefore, be it (See Page 1516)

"RESOLVED: That the Blue Shield organization be encouraged to report cases in which moral principles seem to be involved, to the physician's county medical society for investigation through its ethics or mediation committees. This resolution is not to be interpreted as precluding the right of the Advisory Committee of Michigan Medical Service to call before it individual doctors when it deems such advisable."

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

IX—23. RESOLUTION RE CONTRIBUTIONS TO BEAUMONT MEMORIAL

R. F. FENTON, M.D. (Wayne):

"Whereas, the Beaumont Memorial restoration at Mackinac Island is a monument which will stand for generations as a symbol of pioneering in medical progress, and

"Whereas, every doctor of medicine can be justly proud of this emblem of advancing medical knowledge and of those members who have made it possible, and

"Whereas, the public relations value of this restoration has been and will continue to be extensive, and

"Whereas, the individual subsidy by doctors of medicine rather than by Council action will make every member more aware and a part of this worthy project; be it therefore

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to The Council that the membership-at-large be given one more year of opportunity in which to contribute and at the termination of this time the deficit be met by use of public relations funds of the Michigan State Medical Society." (Reference Committee deleted final clause. See Page 1513.)

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—24. RESOLUTION RE CREATION OF OCCUPATIONAL HEALTH SECTION

O. J. JOHNSON, M.D. (Bay-Arenac-Iosco):

"Whereas, Michigan is a highly industrialized State, and

"Whereas, there is a continuing need for closer relationship between physicians and industry and the development of preventive medical programs in small plants, and

"Whereas, the Committee on Industrial Health of the Michigan State Medical Society has recommended the creation of a Section on Occupational Health in the Michigan State Medical Society as an additional means of bringing information to its members; therefore, be it

"RESOLVED: That a Section on Occupational Health be created in the Michigan State Medical Society."

THE SPEAKER: This is referred to the Reference Committee on Miscellaneous Business.

IX—25. RESOLUTION RE DRIVER TRAINING PROGRAM

J. R. RODGER, M.D. (Northern Michigan):

"Whereas, at the forthcoming special session of the Legislature of Michigan the matter of State subsidy to schools for student driver training will be seriously considered, and

"Whereas, the universal adoption of an adequate driver training program in Michigan's schools within ten years promises at least a 10 per cent reduction in highway fatalities, or the saving of approximately 200 lives a year; therefore, be it

"RESOLVED: That this House of Delegates go on record as strongly endorsing the principle of State subsidy of student driver training; and that each delegate here, and so far as possible each member of the Michigan State Medical Society as an individual citizen, bring this matter to the attention of civic groups in his community as well as to his State senator and representative."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

IX—26. RESOLUTION RE AMA STUDY COMMITTEE ON HIGHWAY ACCIDENTS

J. R. RODGER, M.D. (Northern Michigan): **This is a resolution requesting the Michigan delegation to the American Medical Association to introduce at the forthcoming Boston meeting of the AMA House of Delegates a resolution requesting the Board of Trustees of the American Medical Association to appoint a special committee to study the prevention of highway accidents.**

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—27. RESOLUTION RE EXPANSION OF AMA ADMINISTRATIVE FACILITIES

R. H. PINO, M.D. (Wayne):

"Whereas, the American Medical Association is an organization for which its membership is responsible, and

"Whereas, there is evidence that our responsibilities and the complications of procedure are increasing out of proportion to the increase of aid to our central personnel, and therefore to our delegates and officers, and

"Whereas, this is neither fair nor safe to our central organization and to our officers and delegates whose

combined accomplishments have been outstanding, nor therefore to our membership and the public, and

"Whereas, serious evidences of this are available, and

"Whereas, no occupation is more basically grounded in the method of comprehensive analysis and diagnosis before arriving at conclusions and procedures than the medical profession which can therefore apply increasingly practical methods of leadership, and

"Whereas, the AMA is in need not of reorganization but of increased aid in central management to facilitate diagnostic methods in our problems; therefore, be it

"RESOLVED: That the Michigan delegates to the AMA be instructed to introduce at the next meeting of the House of Delegates a resolution calling for the revision of the Constitution and Bylaws, if necessary, for the creation of the position of Executive Vice President of the American Medical Association; and be it further

"RESOLVED: That the Executive Vice President formulate an investigative staff on the order of a diagnostic clinic for a factual study and processing of major problems; such staff to be made up of the Secretary and General Manager and the Assistant Secretary, together with the current heads of the Departments of Economics, Education, Science, Distribution, Law and Government, Public Relations, and Publications; and that these be supplemented with such aid as may be essential to the purpose of adequate study, the health needs of the public, and the needs of the health professions warrant."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

IX—28. RESOLUTION RE NON-SCIENTIFIC SESSION AT AMA CONVENTION

R. H. PINO, M.D.: This resolution has to do with stimulating an increased study on the part of the specialties concerning their problems, other than scientific, of the distribution of specialty medical care:

"Whereas, many problems other than scientific beset the various Sections as represented in the Scientific Assembly of the American Medical Association, and

"Whereas, most of the nonscientific problems are basic to the distribution of all the medical sciences, and

"Whereas, the heavy agenda of the meetings of the House of Delegates, including that of the reference committees, preclude adequate time for deliberation as compared to the vital importance of much of the material that requires legislative action by the House of Delegates, and

"Whereas, the time allotted to other than scientific problems is practically nil in the various specialty Sections at annual AMA meetings, as is true of state and local specialty meetings throughout the United States, and

"Whereas, this condition dangerously slows up the accumulation of information vital to the medical profession and the House of Delegates in the discharge of its legislative responsibilities; therefore, be it

"RESOLVED: That the Michigan delegates to the AMA, through the AMA House, urge upon the Executive Committee of the Scientific Assembly and of the Section committees the need for time being given for a nonscientific session at national meetings, conducted on subjects of distribution, education, legislation, etc., using the same techniques of procedure as in the scientific sessions, and that important findings and conclusions be turned over to the House of Delegates and others concerned for their deliberation."

THE SPEAKER: We will refer this to the Reference Committee on Resolutions.

IX—29. RESOLUTION RE APPRECIATION OF SERVICE RENDERED BY L. A. DROLETT, M.D.

C. L. WESTON, M.D. (Shiawassee):

"Whereas, an ever-increasing amount of legislation of great significance to the health of the people of Michigan and to the practice of medicine has been and is being considered by the State Legislature of Michigan and by the national Congress, and

"Whereas, the review of these legislative proposals by the Michigan State Medical Society, through its Committee on Legislation, has served the people of this State by significantly improving health facilities and by avoiding tragic errors that would endanger their medical care, and

"Whereas, the Committee on Legislation of the Michigan State Medical Society has been headed for ten years by L. A. Drolett, M.D., of Lansing, who has carried a major responsibility for our success in health legislation efforts; therefore, it be

"RESOLVED: That the House of Delegates of the Michigan State Medical Society does hereby express the thanks and appreciation of the doctors of medicine of Michigan and their patients to L. A. Drolett, M.D., of Lansing, for his unstinting and devoted service, and congratulates him upon the splendid record he and his Committee have made. The House of Delegates sends him its true wishes for continued success."

THE SPEAKER: This will be referred to the Reference Committee on Miscellaneous Business.

The Vice Speaker will take the Chair.

(K. H. Johnson, M.D., resumed the Chair.)

X. REPORTS OF STANDING COMMITTEES

X—1. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

CHAIRMAN JOHNSON:

This report appears on page 79. Is there an additional report?

These reports will all be referred to the Reference Committee on Standing Committees. I won't say that each time.

X—2. COMMITTEE ON PREVENTIVE MEDICINE AND SUBCOMMITTEES

Is there a further report?

Committee on Rheumatic Fever Control.—The report appears on page 86. Is there a further report?

Committee on Cancer Control.—I do not find a report in the Handbook.

Maternal Health Committee and Subcommittees.—The report is on page 89. Is there a further report?

Venereal Disease Control Committee.—The report appears on page 90. Is there a further report?

The Tuberculosis Control Committee report appears on page 93. Is there a further report?

Industrial Health Committee, reported on page 96. Is there a further report?

Child Welfare Committee and Subcommittees.—The report appears on page 99. Is there a further report?

Iodized Salt Committee, appearing on page 100. Is there a further report?

Geriatrics Committee and Subcommittees.—The report appears on page 101. Is there a further report?

X—3. PUBLIC RELATIONS COMMITTEE AND SUBCOMMITTEES

The report begins on page 102. Is there a further report from this Committee?

X—4. ETHICS COMMITTEE

The Ethics Committee report appears on page 113. Is there a further report?

X—5. LEGISLATIVE COMMITTEE

The Legislative Committee's report appears on page 114. Is there a further report?

All of these reports will be referred to the Reference Committee on Standing Committees.

XI. REPORTS OF SPECIAL COMMITTEES

XI—1. BEAUMONT MEMORIAL COMMITTEE

The Beaumont Memorial Committee did not have a report appearing separately in the Handbook, but on page 58 there is a report from The Council concerning the Beaumont Memorial. Is there a further report from that Committee?

XI—2. SCIENTIFIC RADIO COMMITTEE

The report appears on page 119. Is there a further report from this Committee?

XI—3. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The report appears on page 120. Is there a further report?

XI—4. ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

The report appears on page 121. Is there a further report from that Committee?

XI—5. MEDIATION COMMITTEE

There is a report of the Mediation Committee on page 122. Is there a further report from this Committee?

These reports will all be referred to the Reference Committee on Special Committee Reports.

(The meeting recessed at 3:25 p.m.)

MONDAY EVENING SESSION

September 26, 1955

The meeting reconvened at 8:15 p.m., J. E. Livesay, M.D., Speaker of the House, presiding.

IX—30. RESOLUTION RE SPEEDY RECOVERY OF PRESIDENT EISENHOWER

S. E. Gould, M.D. (Wayne):

"Whereas, the President of the United States lies ill at the present moment, and

"Whereas, all Americans are concerned for his well-being; therefore, be it

"RESOLVED: That this House of Delegates of the Michigan State Medical Society, now in session, pause in its deliberations and through its Secretary express its genuine hope for the speedy and full recovery of our President."

The Speaker: This will be referred to the Reference Committee on Miscellaneous Business.

IX—31. RESOLUTION RE COMMITTEE ON DIVISION OF FEES (MMS)

O. J. Johnson, M.D.:

"Whereas, the Board of Directors of Michigan Medical Service has adopted the recommendations of the Special Committee of the Board of Directors of Michigan Medical Service, to divide the scheduled fee of Michigan Medical Service between physicians, and

"Whereas, both the Committee and Board of Directors of Michigan Medical Service have recommended that Michigan State Medical Society develop the methods of implementation of this procedure; therefore, be it

(See Page 1516)

"RESOLVED: That the President of the Michigan State Medical Society appoint a committee to formulate this procedure, and when the methods are approved by The Council of the Michigan State Medical Society they be transmitted to Michigan Medical Service, to be made effective; and be it further

"RESOLVED: That due consideration shall be given to the ethical, legal and administrative and other phases involved."

The Speaker: This resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XII. REPORTS OF REFERENCE COMMITTEES

XII—1. ON OFFICERS' REPORTS

Otto Van Der Velde, M.D. (Ottawa):

XII—1 (a) *President's Address.*—The Reference Committee wishes to commend the address of Dr. Baker, first as to his suggestion of closer relationship of individual county and Michigan medical societies.

Secondly, to commend Dr. Baker's suggestion to protect the well qualified physician against the uncertainty of staff appointments in various hospitals, and we also wish to commend his reminder that all physicians should familiarize themselves more earnestly on legislation at county, State and national levels, especially that which affects medicine as a whole, and recommend approval of same.

XII—1(b) *President-elect's Address.*—The Reference Committee extends commendation and approval to President-elect Dr. William Jones for his address, and wishes to extend the hope and assurance that the House of Delegates of the Michigan State Medical Society and the various county societies will give him their full cooperation during his tenure of office.

XII—1 (c) *Report of Delegates to the AMA.*—The Reference Committee wishes to commend the delegates to the AMA on their action in maintaining the status of teaching hospitals by lowering their intern quotas.

Also, the Reference Committee commends the delegates for requesting the Board of Trustees of the AMA to submit reports of the Committee on Medical Practices in toto, rather than with their deletions. The Reference Committee recommends acceptance of the report as a whole.

XII—1 (d) *Report of Woman's Auxiliary President.*—The Reference Committee wishes to commend the Woman's Auxiliary for their activity on the part of medicine during the past year.

XII—1 (e) *Report of Michigan State Medical Assistants Society.*—The Reference Committee wishes to commend Mrs. Charlotte Ash, President of the MSMAS, for the excellent growth of the organization and its activity in serving the profession.

Mr. Speaker, I move that this report be accepted as a whole.

Otto O. Beck, M.D. (Oakland): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—4. ON REPORTS OF SPECIAL COMMITTEES

XII—4 (a). BEAUMONT MEMORIAL COMMITTEE

E. H. Fenton, M.D. (Wayne): The report will be found on page 56 of the Handbook. The recommendation of The Council is on page 71.

Your Reference Committee acknowledges and extends appreciation to President-elect and Mrs. W. S. Jones for their generous gift to the Memorial in the form of eighty valuable books of the Beaumont era, preserved by courtesy of the Burton Historical Library, and also to the St. Louis Medical Society for a bed used by Dr. Beaumont during his lifetime, and to the Wayne County Medical Society for the loan of its painting.

Your Reference Committee feels the importance of obtaining further donations from the members for this important project, and suggests that The Council inform the members by suitable means of their opportunity still to contribute to this splendid Memorial.

Mr. Speaker, I move adoption of this portion of the report.

F. W. Baske, M.D. (Genesee): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—4(b). SCIENTIFIC RADIO COMMITTEE

E. H. Fenton, M.D.: Your Reference Committee realizes the immense educational value in this series of forty scientific radio programs broadcast over Station WUOM on a large variety of medical subjects. The Scientific Radio Committee is to be commended in the magnitude of this public service and upon their plans to establish a suitable program for the elementary schools.

Mr. Speaker, I move adoption of this portion of the report.

G. T. McKean, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—4(c). ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

E. H. Fenton, M.D.: Your Reference Committee approves the report of this Committee, and wishes to compliment the Auxiliary on another splendid year of achievement.

Mr. Speaker, I move acceptance of this portion of the report.

R. W. Teed, M.D.: Second.

(The motion was put to a vote and was carried unanimously.)

XII—4(d). ADVISORY COMMITTEE TO THE MSMAS

E. H. Fenton, M.D.: Your Reference Committee recognizes the tremendous importance of properly trained medical assistants to the practicing physician. The work of the Advisory Committee to this group is significant in the encouragement of this type of training in other established institutions, such as the Ferris Institute, and in its aid to the Michigan State Medical Assistants Society in their membership drive.

Mr. Speaker, I move acceptance of this portion of the report.

S. E. Gould, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—4(e). MEDIATION COMMITTEE

E. H. Fenton, M.D.: Your Reference Committee has read the report of the Mediation Committee and notes with pleasure that only one case has come before this Committee for mediation, and this apparently is being settled satisfactorily.

Mr. Speaker, I move acceptance of the report of this Committee.

F. W. Baske, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

E. H. Fenton, M.D.: Mr. Speaker, I move acceptance of the report of the Reference Committee as a whole.

R. W. Teed, M.D.: Second.

(The motion was put to a vote and was carried unanimously.)

XII—5. ON CONSTITUTION AND BYLAWS

XII—5(a). RESOLUTION RE COUNTY SOCIETY MEMBERSHIP

S. L. Loupee, M.D. (Dowagiac): The first one on which we will report is the resolution from Oakland County, presented by Dr. Gehringer. The purpose of the resolution is to amend the Bylaws to require the physicians who live near county lines to register in the county society where they have their offices. That is the purpose of the resolution. The Bylaws do not require that at the present time, as you will see by turning to Section 2 of the Bylaws.

The enactment of the provisions of this resolution would create a hardship in many instances. Therefore, it is the opinion of the Reference Committee that this resolution be not approved and the Bylaws be unchanged in this respect.

Mr. Speaker, I move the adoption of this portion of the report of the Reference Committee.

F. P. Rhoades, M.D. (Wayne): Second the motion.

The Speaker: The motion is that the Bylaws be not changed.

(The motion was put to a vote and was carried, but not unanimously.)

XII—5(b). RESOLUTION RE ELECTION OF EXECUTIVE COMMITTEE OF THE COUNCIL

S. L. Loupee, M.D.: Mr. Speaker, our second resolution was introduced by the Ingham County Society, Dr. Troost being their spokesman. This would provide for a complete reorganization of The Council. It also involves such a radical change in the function of The Council, as viewed by the Reference Committee, that our report carries with it nonapproval of this resolution.

It is the opinion of the Reference Committee that the resolution as presented might seriously hamper the functions of The Council, and would add little to its efficiency. The resolution was disapproved by the Reference Committee.

I move approval of the report of the Reference Committee.

A. E. Schiller, M.D.: Second the motion.

The Speaker: The motion is to disapprove the resolution. Is there further discussion?

(The motion was put to a vote and was carried, but not unanimously.)

S. L. Loupee, M.D.: I move the adoption of the report of the Reference Committee as a whole.

J. B. Blodgett, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—8. ON LEGISLATION AND PUBLIC RELATIONS

XII—8(a). RESOLUTION RE PERIODIC HEALTH EXAMINATIONS BY HOSPITALS

F. D. Johnson, M.D. (Genesee): This resolution was presented by Dr. O. B. McGillicuddy of Ingham County.

In this resolution he asks that consideration be given by hospitals to the doctor-patient relationship in the examination of those individuals presenting themselves at a hospital for periodic health examinations, and that this be put on a local basis.

I will read the "Resolves":

"RESOLVED: That the hospital medical staffs choose the physicians for these examinations by rotation from all those qualified to conduct such examinations; and be it further

"RESOLVED: That while hospital medical staffs may agree on a local solution to this problem, each hospital staff must not lose sight of the physician-patient relationship which is primarily the concern of the county medical society as a unit."

I move the adoption of this report.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

XII—8(b). REGARDING THE JENKINS-KEOGH BILL

F. D. Johnson, M.D.:

"RESOLVED: That the Michigan State Medical Society supports the Jenkins-Keogh bill; and be it further

"RESOLVED: That copies of this resolution be sent to all Congressmen and both U. S. Senators from the State of Michigan."

I move adoption.

J. B. Blodgett, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—8(c). RESOLUTION RE SCREENING OF FOREIGN INTERNS

F. D. JOHNSON, M.D.:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly recommend to the State Board of Registration a resumption of the previous methods of handling and admitting foreign graduates, or a modification of the present ruling which will permit a suitable time for these graduates to learn medical English before presenting themselves for examination."

I move the adoption of this resolution.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—8(d). RESOLUTION RE THE BEAUMONT MEMORIAL PRESERVATION

F. D. JOHNSON, M.D.:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society express its deep appreciation to the Michigan Legislature for its complimentary action in adoption of Senate Concurrent Resolution No. 34; and be it further

"RESOLVED: That in the interest of preservation of the Beaumont Memorial and its future expansion as an historic shrine, the Michigan State Medical Society respectfully urges the Michigan Legislature (a) to continue its interest in the Beaumont Memorial, and (b) in order to better meet this purpose, to authorize an advisory committee of the Michigan State Medical Society to confer each year (or more often, as necessary) with the Mackinac Island State Park Commission as an advisory group on the maintenance and improvement of the Beaumont Memorial; and be it further

"RESOLVED: That the Michigan State Medical Society respectfully and urgently suggests that the Michigan Legislature, at its earliest convenience, study and put into action a program which would encourage other professional groups, trade associations, and civic and historical organizations, to adopt projects supported by voluntary financial contributions for restoring and renovating and many other historical sites in the Mackinac Island State Park as a reminder of the remarkable part Michigan has played in many fields of American scientific, cultural and political progress."

I move adoption of this portion of the report.

O. B. MCGILLICUDDY, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—8(e). RE FEE FOR EXAMINATION OF MENTALLY ILL

F. D. JOHNSON, M.D.:

"Whereas, the fee established by legislative enactment for the examination of mentally ill has not been increased in over twenty years, and

"Whereas, this makes it difficult for the Probate Court to obtain such examinations; therefore, be it

"RESOLVED: That the Michigan State Medical Society take steps to bring an increase in this fee."

I move adoption of this portion of the report.

S. L. LOUPEE, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—8(f). RESOLUTION ON DRIVER TRAINING

F. D. JOHNSON, M.D.:

"RESOLVED: That this House of Delegates go on record as strongly endorsing the principle of State subsidy of student driver training; and that each delegate here, and as far as possible each member of the Michigan State Medical Society as an individual citizen, bring this matter to the attention of civic groups in his community, as well as to his State senator and representative."

I move the adoption of this portion of the report.

W. W. BABCOCK, M.D.: Second the motion.

CHAIRMAN JOHNSON: The motion is to approve. Are you ready for the question?

(The motion was put to a vote and was carried unanimously.)

XII—8(g). RESOLUTION RE HOSPITAL FACILITIES FOR MENTALLY ILL

F. D. JOHNSON, M.D.: (The complete resolution was read.) I move acceptance of this portion of the report.

W. A. SCOTT, M.D. (Kalamazoo): Second the motion.

DR. O. K. ENGELKE (Washtenaw): I move to table the motion until tomorrow morning. (See Page 1509.)

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

XII—8(h). RESOLUTION RE INCREASING HOSPITAL PERSONNEL FOR MENTALLY ILL

(Dr. Johnson read the Resolved portions of resolution No. 17.)

F. D. Johnson, M.D. (continuing): The Reference Committee recommends that this resolution be referred to the Mental Health Committee for further study before being presented to the House of Delegates.

I so move.

J. B. BLODGETT, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

F. D. JOHNSON, M.D.: I move the adoption of this report as amended.

S. E. GOULD, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

VICE SPEAKER JOHNSON: Thank you, Dr. Johnson.

(The Speaker resumed the Chair.)

XII—10. ON MISCELLANEOUS BUSINESS

XII—10(a). RESOLUTION OF THANKS AND APPRECIATION TO L. A. DROLETT, M.D., OF LANSING

G. S. BATES, M.D. (Wayne): The Reference Committee recommends approval of the resolution, and I move its adoption.

R. V. WALKER, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—10(b). RESOLUTION RE MEDIC—COMMENDATION TO LOS ANGELES COUNTY MEDICAL SOCIETY

G. S. BATES, M.D.: The Reference Committee approves this resolution. I move the adoption of this recommendation.

L. R. LEADER, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—10(c). RESOLUTION RE THE CREATION OF A SECTION ON OCCUPATIONAL HEALTH OF THE MICHIGAN STATE MEDICAL SOCIETY

G. S. BATES, M.D.: The Reference Committee approves this resolution, and I therefore move its adoption.

J. A. KASPER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.) (See Page 1504 for fourth Resolution referred to the committee.)

IX—32. RESOLUTION RE CALIFORNIA CANCER COMMISSION

C. W. COLWELL, M.D.: Mr. Speaker, I have a resolution to offer:

"Whereas, the cancer quack does untold damage with his treatment of curable cancer until it is incurable,

thereby actively assisting the disease in destroying the patient, and also destroying the faith of the public in recognized methods of treatment, and

"Whereas, the California Cancer Commission has recognized this and other facts and has maintained a Cancer Commission since 1931, and this Commission has led an active attack on quackery, and

"Whereas, there is no doubt about the efficacy of this attack as shown by the continued reappointment and broadened activities of this Commission; therefore, be it

"RESOLVED: That the Genesee County Medical Society recommend to the Michigan State Medical Society that a committee be appointed to investigate the workings of the California Cancer Commission and others now functioning, and to make recommendations concerning the advisability of organizing a Michigan Cancer Commission or to utilize existing committees for the purpose of investigating, evaluating and exposing all so-called cancer cures that are presently known or may appear in the State of Michigan."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions. The meeting is recessed until 9:30 tomorrow morning.

(The meeting recessed at 10:05 p.m.)

TUESDAY MORNING SESSION

September 27, 1955

The meeting reconvened at 9:45 a.m., J. E. Livesay, M.D., Speaker of the House, presiding.

XII—8(g). HOSPITAL FACILITIES FOR MENTALLY ILL

O. K. ENGELKE, M.D.: Mr. Speaker, if you will recall, last evening I moved that the resolution No. 16, presented by the Committee on Legislation and Public Relations, be tabled until this morning to permit me to prepare an amendment to the resolution.

At this time I would like to move that this resolution be removed from the table.

E. G. M. KRIEG, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Would you like to have the Chair read the motion, or do you have the motion in question before you?

O. K. ENGELKE, M.D.: I have a copy of the motion. In the event it may not be complete, I will be pleased to have the Chair read the one that is available.

THE SPEAKER: The motion on the floor is to approve this resolution.

(The Speaker re-read resolution.)

O. K. ENGELKE, M.D.: Mr. Speaker, I am in complete accord with the resolution as it has been read. My amendment will not change the content. However, I have been acutely aware in the past year of the possibility that in an effort to care for mentally defectives, the rather efficient tuberculosis control program now under way, and planned for Michigan, might be jeopardized.

I am also aware of the fact that the Committee and the original presentors of this resolution had no such thing in mind. However, it is my belief that the resolution as presented might be misconstrued by well-intentioned people, and so I offer this amendment to the resolution. The amendment is simply to add, at the end of the resolution as it now stands, the following:

"And be it further RESOLVED: That such definitive action not be allowed to impair in any way the efficient tuberculosis control programs now in effect and planned for this State; and be it further

"RESOLVED: That copies of this resolution be delivered to all of the State legislators as well as the Governor before the next session of the Legislature."

Mr. Speaker, I move this as an amendment.

R. W. TEED, M.D.: Second the motion.

(The amendment was put to a vote and was carried unanimously.)

(The motion as amended was then put to a vote and was carried unanimously.)

XII—2. ON REPORTS OF THE COUNCIL

L. J. BAILEY, M.D.: Mr. Speaker, the Reference Committee on Reports of The Council wishes particularly to commend The Council on the large amount of Society business which it transacted during the year, representing, as it did, 121 hours of deliberation, as reported in the preamble to the report.

Membership.—The Reference Committee noted the reported increase in membership with gratification.

Finances.—The supplemental report of The Council called attention to the critical status of the General Fund. It moved to adopt the recommendation of The Council to increase Society dues by $10. After discussion with the Chairman of the Finance Committee, the Reference Committee was assured that fully adequate consideration had been given by The Council to the matter of possible economies, and that the needs of the Society genuinely require additional income.

The Journal.—The Reference Committee commends the Editor and the Publications Committee on the continuing quality of THE JOURNAL—its scientific material and format.

Organization.—This part of the report was reviewed, and the recommendation of The Council to extend the County Secretaries-Public Relations Conference from one to three days was favorably received.

The Reference Committee regrets the financial loss incurred by the Michigan Clinical Institute. Meetings are multiplying, and it was the feeling of the Reference Committee that competition between the Michigan Clinical Institute and groups which it was intended to benefit might profitably be merged with the Michigan Clinical Institute, to the benefit of each.

The Resident Intern and Senior Medical Student Conference, held coincidentally with the Michigan Clinical Institute, was especially commended, together with the action on the part of the Michigan State Medical Society in sending delegates to the Student AMA convention.

It was noted that the indoctrination of the new MSMS members and medical students was successfully being carried on, and the Reference Committee urges the desirability of continuing this activity in the case of students, not necessarily early in their medical school career, but in any event extracurricular, if time does not permit inclusion of this activity in the medical school's teaching program.

The remainder of that portion of the report dealing with organization was approved, as was the entire portion following, on public relations. The public relations program is enthusiastically supported and should continue.

Woman's Auxiliary.—The report of The Council on the activities of the Woman's Auxiliary adequately reflects the achievements of this organization under the energetic leadership of Mrs. Albert F. Milford.

Contacts with Voluntary Agencies and Organizations.—The original and supplementary report regarding Michigan Medical Service was reviewed, and we recommend that the members of the Michigan State Medical Society respond realistically to the request that they aid in the development of the fee schedule for the $6,000 family income level medical-surgical care policy.

Thanks are extended to the Beaumont Memorial Committee and to its Chairman, Otto O. Beck, M.D., for the completion of this fitting memorial. The large deficit incurred by the project is looked upon with regret, and the membership of the Society is urged, in the spirit of that pride, allusion to which is made in the recom-

mendations of The Council, to contribute to the Beaumont Fund the sum which is needed to erase the deficit.

The Council is commended for the caution and circumspection with which it dealt with the difficulties posed by the vexatious manner with which the Salk polio vaccine was introduced to the public and to the profession.

Reports of Committees of The Council

Committee to Co-operate with the Michigan Health Council re Periodic Health Appraisal.—It is emphasized that the periodic health examination should be promoted, and especially in the spirit of the recommendation of The Council that this function reside with the private practitioner. It is stressed that the objective of the program is to apprehend incipient disease, to which end an adequate physical and laboratory examination will be required.

Hospital Relations Committee.—The activity of this Committee was particularly meritorious. The recommendations of the Committee are approved.

Matters Referred to The Council

No changes or recommendations were made, with the exception of that portion of the report and the supplemental report which dealt with migrant workers.

Dr. Sladek's letter was reviewed, and Dr. Sladek addressed the Reference Committee. He amplified the information read by the Chairman of The Council in his supplemental report. The recommendations implied in his letter were strongly approved, and this House is therefore asked to empower the Executive Secretary of the Michigan State Medical Society actively to promote a program in the counties involved with the migrant worker, to the end that a workable insurance program be developed well in advance of the 1956 season, through meetings with the growers, as indicated in the report.

Supplemental Report

MSMS Health and Accident Insurance Program.—Attention is called to the high loss ratio of 61 per cent incurred by the health and accident insurance program. A higher participation on the part of members would reduce this loss; but the Reference Committee is unable to make any recommendations.

Contacts with Governmental Agencies.—It was noted with pleasure that the liaison committee with the State's Executive Office had been well accepted, and the election of E. C. Swanson, M.D., to the position of Secretary of the Michigan State Board of Registration in Medicine was approved. Further, the hope was expressed that this interim filling of the office of Secretary will ultimately be confirmed by the Governor and Legislature of this State.

Standards of Membership.—The progress report of the Committee of The Council on Mediation, Grievance and Ethics was accepted.

Annual Reports of Committees.—The special committee which studied the resolution re Joint Commission on Accreditation made six recommendations, which were approved. It is understood that in the wording of paragraph 5, "Basically, we believe that the policy underlying the establishment of outpatient departments should be determined by the local county medical society," it was the intent of the Committee of The Council that the necessity for outpatient departments be determined by the county medical society strictly, with local needs as the determining factor. This wording should be incorporated in this part of the report.

With this change, the report is enthusiastically adopted, together with the recommendation of The Council on this subject at the end of its report.

Michigan State Medical Assistants Society.—The activities of the Medical Assistants' Society, under the leadership of Mrs. Charlotte Ash, as reported by The Council, were noted with approval, and every encouragement is extended to this organization. Doctors are asked to invite their *eligible* personnel to ally themselves with the Society.

Matters Referred to The Council.—Your Reference Committee hopes that the highly desirable Uniform Health Insurance Claim forms will soon materialize. Anything that simplifies anything is good.

The supplemental report on the basic science law was much more detailed than the original report, although the improvements in the basic science law described in each report are essentially the same.

The conclusions and recommendations appended to the supplemental report were accepted with commendation, and the recommendation that the Committee be continued.

Mr. Speaker, I move the adoption of the original and supplemental reports of The Council, with the one minor addition suggested, and including the specific recommendations of The Council and the Reference Committee.

May I acknowledge gratefully the patient co-operation of the members of the Reference Committee, and the members of the House of Delegates and The Council who aided in our deliberations.

(The motion was severally seconded.)

W. W. BABCOCK: **I would like to offer an amendment to Dr. Bailey's motion to approve the report, that as far as the raise in dues is concerned, a study committee, composed of members of this House of Delegates, be appointed by the Chair to study this problem for one year, and report at the next annual session.**

E. A. BICKNELL, M.D. (Wayne): I would like to amend Dr. Babcock's amendment, that a study committee be appointed for next year, and that the increase be an assessment of $10 for one year until the committee reports next year.

I so move.

E. G. M. KRIEG, M.D.: I second that.

THE SPEAKER: The action now is to have a special assessment of $10, for one year only, next year, and that a study committee be appointed to recommend to the next House of Delegates. Are you ready for the question? Those in favor will say "aye"; opposed, "no." We will have a show of hands. Those in favor of the motion will raise their hands. (65). Those voting "no," raise your hands. (27).

The "ayes" have it and the motion is carried.

We are now back to Dr. Babcock's amendatory motion. Dr. Babcock's motion carries with it the appointment of a study committee from the House of Delegates, to be appointed by the Chair with the approval of the President of the Society, as provided for in the Constitution.

Are you ready for that motion? Those in favor will say "aye"; opposed, "no." The motion as amended is carried.

We are now back to the report of the Reference Committee on Reports of The Council. Is there further discussion? The motion is to approve the report of the Reference Committee on Reports of The Council as amended.

(The motion was put to a vote and was carried unanimously.)

L. J. BAILEY, M.D.: The Reference Committee received a resolution from Dr. Wellman, that the House of Delegates of the Michigan State Medical Society instruct its delegates to the House of Delegates of the AMA to ask for a review of the actions and recommendations of the Joint Commission on the Accreditation

of Hospitals by a committee, the majority of which shall be selected from doctors of medicine actively engaged in private practice.

The resolution as introduced is not clear as to intent, and it is referred back to the proposer for clarification.

I so move.

A. E. SCHILLER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. Bailey, will you continue.

L. J. BAILEY, M.D.: Mr. Speaker, I move the adoption of the report as a whole.

M. R. WEED, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—3. ON REPORTS OF STANDING COMMITTEES

H. F. FALLS, M.D.: Mr. Speaker and delegates, this is the report of the Reference Committee on Reports of Standing Committees:

XII—3(a). POSTGRADUATE MEDICAL EDUCATION COMMITTEE

In reviewing this report your Reference Committee was favorably impressed with the wide scope and excellence of the subject material presented at the fall and spring postgraduate programs. Most favorable commendation was expressed by the members of the Reference Committee for the excellence of presentation on the part of the majority of the selected speakers.

A vote of sincere thanks was approved for those men who gave so freely of their teaching services in this program. The Reference Committee is heartened by the apparent fact that there is no significant waning in interest in postgraduate medicine on the part of practitioners in Michigan. The Reference Committee would like to recommend a more vigorous advertisement at a local level of the forthcoming programs.

The Reference Committee approved this report as published in the Handbook. Mr. Speaker, I move the adoption of this report.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—3(b). PREVENTIVE MEDICINE COMMITTEE

H. F. FALLS, M.D.: Since this report includes a number of summaries of the work of advisory subcommittees, disposition of this particular Committee's report is deferred until the ancillary committee reports are separately considered:

(a) Annual Report of the Committee on Rheumatic Fever Control: The Reference Committee was impressed with the industry and accomplishment of this Committee. The Committee's report as published in the Handbook was approved.

Mr. Speaker, I move the adoption of this report.

J. A. KASPER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

H. F. FALLS, M.D.: *(b) Annual Report of the Maternal Health Committee:* The Reference Committee notes that this Committee is continuing the survey of maternal mortality, and that the results of the first three years' work have been published in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

Mr. Speaker, I move the adoption of this report.

J. B. BLODGETT, M.D.: Second.

(The motion was put to a vote and was carried unanimously.)

H. F. FALLS, M.D.: *(c) Annual Report of the Venereal Disease Control Committee:* The matter of prophylaxis for gonorrheal ophthalmia neonatorium was discussed at length by your Reference Committee. The suggestion that 1 per cent penicillin ointment be substituted for 1 per cent silver nitrate is believed by the Reference Committee to be fraught with potential danger, in light of a reported increasing incidence of penicillin-fast organisms and an occasional sensitization encountered with topical administration of this drug.

We will await with interest the results of the seven-county mobile trailer examination of the migratory agricultural workers.

The Reference Committee approved this report as printed in the Handbook, and recommends its adoption.

Mr. Speaker, I so move.

G. W. DEBOER, M.D. (Kent): Second the motion.

(The motion was put to a vote and was carried unanimously.)

H. F. FALLS, M.D.: *(d) Annual Report of the Tuberculosis Control Committee:* The Reference Committee urges the careful perusal of this report by each of the delegates in an effort to further emphasize the following points:

1. Decreasing utilization of tuberculosis beds in Michigan.

2. The economic dilemma of the county and municipal tuberculosis institutions.

3. The need for subsidization of these same institutions.

The Reference Committee would like to support the Committee's recommendation that the Michigan State Medical Society form a commission to study this situation and other problems concerning tuberculosis hospitals in Michigan.

It is urged that the delegates should bring to the attention of their county society program chairmen the generous offer of the Michigan Tuberculosis Association to defray expenses of prominent speakers on tuberculosis upon request of local medical societies.

The report of this Committee was approved as printed in the Handbook, and the Committee congratulated for its industry.

Mr. Speaker, I move the adoption of this report.

C. W. SELLERS, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.

H. F. FALLS, M.D.: *(e) Annual Report of the Committee on Industrial Health:* The Reference Committee supported the recommendation of this Committee that a Section on Occupational Health be created in the Michigan State Medical Society.

The Reference Committee approved the report of the Committee as published in the Handbook.

Mr. Speaker, I move the adoption of this report.

W. W. BABCOCK, M.D.: Second.

(The motion was put to a vote and was carried unanimously.)

H. F. FALLS, M.D.: *(f) Annual Report of the Committee on Mental Health:* The Reference Committee was impressed with the orderly and precise nature of this Committee's report. The recommendation that the component county medical societies form committees on mental health should be given serious consideration, as should also the establishment of a committee on medical testimony on a State level.

The Reference Committee approved the report of the Committee as published in the Handbook.

Mr. Speaker, I move the adoption of this report.

R. W. TEED, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously.)

H. F. FALLS, M.D.: *(g) Annual Report of the Child Welfare Committee:* This report was approved as published in the Handbook. This Committee and its Subcommittee deserve our thanks for jobs well done.

Mr. Speaker, I move the adoption of this report.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

H. F. FALLS, M.D.: *(h) Annual Report of the Iodized Salt Committee:* The Reference Committee approved the report of the Committee as presented in the Handbook.

Mr. Speaker, I move the adoption of this report.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

H. F. FALLS, M.D.: At the suggestion of the Speaker I will read the remainder of the report of the Reference Committee:

(i) Annual Report of the Geriatrics Committee: The Reference Committee wishes to commend the increasing scope and activity of this Committee, and particularly notes the success and reputation that the conferences on the aging system are enjoying.

The Reference Committee approved the report of this Committee as published in the Handbook.

We will now finally consider the annual report of the Preventive Medicine Committee.

The *Subcommittee on Cancer Control* did not submit a report; otherwise, the reports of the various subcommittees have been reviewed. The proposed expansion of the *Scientific Radio Committee* is commended. The Reference Committee wishes to echo the thanks extended to A. E. Heustis, M.D. and J. K. Altland, M.D., for their courteous and helpful support and consultation.

XII—3(c). PUBLIC RELATIONS COMMITTEE

The activity of this Committee was most highly endorsed by the Reference Committee.

The publication, "Winning Friends for Medicine," warrants the endorsement of all physicians.

The significant interest in the promotion of public relations has become evident in all county societies. The success of the Committee in thwarting legislative action to control the professional fee for polio vaccinations is evident.

The utilization of movies, radio, television and the press to tell the story of medicine in Michigan has been thoughtfully and judiciously exploited by this Committee. The Reference Committee highly approves the honoring of six daily newspapers in Michigan for their public service in promoting better understanding of medical progress and of the medical profession.

The Reference Committee endorses and wishes to quote the concluding sentence of this Committee's report: "The Committee reaffirms its belief that the most effective public relations program for the medical profession must be rooted in sincere action on the part of county medical societies and the conscientious practice of personal public relations in the private office of the individual physician."

XII—3(d). ETHICS COMMITTEE

This report was approved by the Reference Committee as printed in the Handbook.

XII—3(e). LEGISLATIVE COMMITTEE

As has been previously noted, the vigilance and guidance of this Committee on subject material brought before our State Legislature is most assuring. It is indeed encouraging to note that the legislators are beginning to seek the advice of this Committee on matters pertaining to health and medicine. The concluding sentence of this Committee's report may be altered somewhat in its original intent, but best expresses the sentiments of the Reference Committee when we quote: "They deserve the heartfelt thanks not only of their colleagues, but all the citizens of Michigan."

The Reference Committee approves the report of this Committee as published in the Handbook.

Mr. Speaker, I move the adoption of these reports as a whole.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6. REFERENCE COMMITTEE ON RESOLUTIONS

XII—6(b). RESOLUTIONS RE COMMENDATION OF DR. ROBERT L. NOVY

W. L. BROSIUS, M.D.: Inasmuch as the intent of these resolutions was identical, the Reference Committee recommends the adoption of all three resolutions, but suggests that they be incorporated into one suitably inscribed scroll for presentation to Dr. Novy.

I so move.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(c). RESOLUTION RE "THE VOICE OF AMERICA"

W. L. BROSIUS, M.D.: The Reference Committee recommends adoption of this resolution, and I so move.

C. W. SELLERS, M.D.: Second the motion.

VICE SPEAKER JOHNSON: All those in favor, respond by "aye"; opposed, "no." The motion is carried.

XII—6(d). RESOLUTION RE HOSPITAL PRIVILEGE

W. L. BROSIUS, M.D.: The Reference Committee considered this resolution in four parts, as there are four separate items covered in it.

Item 1: The Reference Committee recommends the adoption of this part of the resolution as submitted.

Item 2: The Reference Committee recommends the adoption of this part of the resolution as submitted.

Item 3: The Reference Committee recommends the substitution of the following wording for this portion of the resolution: **"That the AMA Public Relations Committee recommend to the various specialty boards consideration of the hardships imposed on recent diplomates by the restrictive regulations which limit their practice of their specialty during the early years of establishing a practice."**

Item 4: The Reference Committee recommends the substitution of the following wording for this portion of the resolution: **"That the AMA, through its official channels, encourage the formation of general practice sections in the organization of hospital staffs, and that each staff applicant be evaluated on his individual merit."**

Mr. Chairman, your Reference Committee recommends the adoption of its report, and I so move.

W. W. BABCOCK, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(e). RESOLUTION RE OA AND SI PROGRAM (SOCIAL SECURITY)

W. L. BROSIUS, M.D.: The Reference Committee recognizes the importance of the subject matter of this resolution, but recommends that the resolution be not adopted, for the reason that it may jeopardize the progress already made by the AMA toward the passage of the Jenkins-Keogh bill. Because the Reference Committee feels that further study of this matter is essential, the Reference Committee suggests that educational matter be obtained by The Council and disseminated by various means of communication to the county societies, and

that a poll be conducted by each county society to determine as accurately as possible the consensus of the medical profession in the State, and that the result of this poll be presented to the House of Delegates at the 1956 session.

Your Reference Committee heard from two counties that had conducted such polls and that had voted not to be included in social security. From another organization, including physicians, the result was similar. The Reference Committee did not feel that this State Society could go on record at this time without further information, and hence the recommendation.

I so move.

J. E. LOFSTROM, M.D. (Wayne): Second the motion.

F. L. TROOST, M.D.: I would like to amend the Reference Committee's motion, that the poll conducted on a State level for the State Medical Society be in writing. Not necessarily that each doctor has to sign his own name, but that the Secretary of the Society send out a letter to each member of the Society, rather than have it on a county level.

P. S. BARKER, M.D. (Washtenaw): I second that.

L. R. LEADER, M.D.: Just a word or two on the amendment. It seems that a moment or two ago we discussed the idea that the dues in the State were too high, and that we should cut down on various committee work. Now we have an amendment to have the State conduct this poll, which would be another expense. I see no reason for the counties not conducting their own poll and turning in the results to the State, which will cut down our expenses.

(The amendment was put to a vote and was lost.)

VICE SPEAKER JOHNSON: We are now back to the motion itself.

(The motion was put to a vote and was carried, but not unanimously.)

XII—6(f). RESOLUTION RE POSSIBLE OPTOMETRIC LEGISLATION

W. L. BROSIUS, M.D.: The Reference Committee recommends the adoption of this resolution, and I so move.

C. W. SELLERS, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(g). RESOLUTION RE "BEAUMONT MEMORIAL CONTRIBUTIONS"

W. L. BROSIUS, M.D.: The Reference Committee recommends the adoption of the resolution as presented.

I move that we adopt this resolution.

P. C. GITTINS, M.D. (Wayne): Second the motion.

E. A. OSIUS, M.D.: As it reads now, we will make the effort for a year, and if it is not successful the money will have to be taken out of public relations funds. If you do that you will immediately weaken any attempt to collect from the membership, because they will say, "Oh, well, it will be paid for by the Public Relations Committee anyway," so we might leave the public relations business out of it, and then your back won't be against a wall.

W. L. BROSIUS, M.D.: The purpose of the resolution was to clear the books of this matter. It hangs on the books from year to year as a debt—as a loan from the funds to the Beaumont Memorial Committee, who want to clear the books.

We have a suggestion which I would like to read at this time:

"The Reference Committee further suggests that The Council of the Michigan State Medical Society urge each component county society to continue its efforts to raise their participation of each county society to 100 per cent of their membership, and to call the Beaumont Memorial project to the special attention of new members."

There have been members taken in who have not had an opportunity to contribute. This was a voluntary project. The funds were raised within this Society by voluntary means. It is still the doctors' project, and the remaining funds are coming from the doctors; but the opportunity for voluntary contributions will end in a year, and we will write it off the books at that time by assignment of another fund. Is that clear?

The Reference Committee recommends the adoption of the resolution as presented.

L. J. BAILEY, M.D.: I am in favor of the intent of Dr. Osius's discussion. May the resolution be read again, please?

(The resolution was re-read.)

L. J. BAILEY, M.D.: As I said, I was in favor of the discussion as advanced by Dr. Osius, and if I am not out of order I should like to amend Dr. Osius's amendment by concluding his motion at the word "contribute."

CHAIRMAN JOHNSON: The motion made by Dr. Bailey, which is in the form of an amendment, has the effect of deleting the last portion of the "Resolved," and stopping at that point. I will read it as it would then state:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to The Council that the membership at large be given one more year of opportunity in which to contribute."

E. G. M. KRIEG, M.D.: I second that.

(The amendment was put to a vote and was carried unanimously.)

CHAIRMAN JOHNSON: Now we need a motion to adopt it as amended.

W. L. BROSIUS, M.D.: Mr. Speaker, I so move.

C. I. OWEN, M.D. (Wayne): Second.

(The motion as amended was put to a vote and was carried unanimously.)

W. L. BROSIUS, M.D.: **The Reference Committee further suggests that The Council of the Michigan State Medical Society urge its component county societies to continue their efforts to raise their participation of each county society to 100 per cent of their membership, and to call the Beaumont Memorial project to the special attention of new members.**

Your Reference Committee recommends the adoption of this suggestion, and I so move.

S. L. LOUPEE, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(h). RESOLUTION RE AMA STUDY COMMITTEE ON HIGHWAY ACCIDENTS

W. L. BROSIUS, M.D.: "Requesting the Michigan delegation to the American Medical Association to introduce at the forthcoming Boston meeting of the AMA House of Delegates a resolution requesting the Board of Trustees of the American Medical Association to appoint a special committee to study the prevention of highway accidents."

Your Reference Committee recommends the adoption of the resolution, and I so move.

E. G. M. KRIEG, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6 (i). RESOLUTION RE EXPANSION OF AMA ADMINISTRATIVE FACILITIES

W. L. BROSIUS, M.D.: The Reference Committee recommends that the resolution as presented be not adopted, and recommends the adoption of a *substitute resolution* as follows:

"Whereas, there is evidence that our responsibilities and the complications of procedure are increasing out of proportion to the increase of aid to our central personnel, and therefore to our delegates and officers, and

"Whereas, this is neither fair nor safe to our central organization and to our officers and delegates whose

combined accomplishments have been outstanding, nor therefore to our membership and the public; therefore, be it

"RESOLVED: That the Michigan delegates to the AMA be instructed to introduce at the next meeting of the House of Delegates a resolution calling for the revision of the Constitution and Bylaws, if necessary, for the creation of the office of Executive Vice President of the American Medical Association; and be it further

"RESOLVED: That at the discretion of the officers and delegates, the present Secretary and General Manager be considered for the position of Executive Vice President."

Your Reference Committee recommends the adoption of the substitute resolution, and I so move.

E. C. TEXTER, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(j). RESOLUTION RE NONSCIENTIFIC SESSION AT AMA CONVENTIONS

W. L. BROSIUS, M.D.: The Reference Committee recommends that the resolution as presented be not adopted, and recommends the adoption of a substitute resolution as follows:

"Whereas, many problems other than scientific beset the various sections as presented in the Scientific Assembly of the American Medical Association, and

"Whereas, most of the nonscientific problems are basic to the distribution of all the medical sciences and are essential to medical welfare; therefore, be it

"RESOLVED: That the Michigan delegates to the AMA, through the AMA House of Delegates, urge upon the Executive Committee of the Scientific Assembly and of the section committees the need for sufficient time being allotted for discussion at national meetings on subjects of distribution, education, legislation, and so on, using the same techniques of procedure as in the scientific sessions, and that important findings and conclusions be turned over to the House of Delegates and others concerned for their deliberation."

Yor Reference Committee recommends the adoption of the substitute resolution, and I so move.

J. A. KASPER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—6(k). RESOLUTION RE CALIFORNIA CANCER COMMISSION

W. L. BROSIUS, M.D.: The Reference Committee recommends the adoption of this resolution as presented.

There is already a Cancer Committee; there is also a Cancer Commission. Your Reference Committee recognizes the merit of the resolution and the need for considering the cancer quack problems specifically and the valuable work done by the California committee.

The resolution recommends the appointment of a committee. If the President or whoever appoints committees appoints the Cancer Committee for the investigation of this problem, it will satisfy the resolution.

Your Reference Committee recommends the adoption of the resolution as presented, and I so move.

J. E. LOFSTROM, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously.)

W. L. BROSIUS, M.D.: Mr. Chairman, I move adoption of the report as a whole, as amended.

R. V. WALKER, M.D.: Second the motion.

M. L. LICHTER, M.D. (Wayne): I would like to offer an amendment to Dr. Brosius's motion, that the record of the action of this House in reference to the commendation of the President of the Woman's Auxiliary be expunged from the record of the proceedings of this House. I feel that this is something of a rather personal nature, and it is something which will be subject to misinterpretation if it gets into our public record, and will imply criticism when none was implied.

A. W. STROM, M.D. (Hillsdale): Second.

(The amendment was put to a vote and was carried unanimously.)

VICE SPEAKER JOHNSON: That was in the form of another amendment to the proceedings of this Reference Committee. What is your pleasure in regard to the adoption of the report as a whole, as amended? Are you ready for the question?

(The motion was put to a vote and was carried unanimously.)

XII—9. ON HYGIENE AND PUBLIC HEALTH

XII—9(a). RESOLUTION RE PROPAGANDA ON SALK POLIO VACCINE

O. K. ENGELKE, M.D.: The Reference Committee and those advising us carefully considered this resolution, and we have prepared a substitute resolution which we think catches the spirit of the original resolution as presented, but which would be more acceptable and would better serve the citizens of the State of Michigan as well as the Society. I will read the substitute resolution:

"Whereas, the medical profession has accumulated a tremendous amount of practical experience in the proper methods of initiating new programs for the protection of the health of the people, and

"Whereas, this experience includes the administration of many different vaccines for the prevention of virus and other diseases, and

"Whereas, members of the medical profession must, in the public mind, inevitably share responsibility for any confusion or tragic consequences of the improper introduction of new procedures, and

"Whereas, the medical profession has, in the public interest, repeatedly demonstrated its desire to co-operate with its own members and with others in the implementation of such health procedures, when given time to properly review and evaluate them; now, therefore, be it

"RESOLVED: That this Society respectfully urge all legislative bodies, lay, private, and official public health agencies, to avail themselves of their opportunity to consult with the proper committees of this Medical Society and other medical societies concerned, before new health procedures are introduced; and that these private and public health agencies provide such medical societies with all scientific data available in time for its careful evaluation before programs are started; and that such legislative bodies, lay private, and official public health agencies recognize the rich experience of this and other medical societies when their advice is given for the planning of new health programs."

Mr. Speaker, I move the adoption of this resolution prepared by the Reference Committee.

D. I. SUGAR, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—9(b). RESOLUTION RE FLUORIDATION OF WATER

O. K. ENGELKE, M.D.: The Reference Committee wishes to recommend the rejection of this resolution for several reasons. They are:

1. On two previous occasions within the past five years this House has approved in principle the addition of controlled amounts of fluoride compounds to the drinking water as a safe and effective way to reduce tooth decay.

2. Our action was but one of many similar approvals recorded after careful research and study by the American Dental Association, the U. S. Public Health Service, as well as other state and local medical societies like our own.

3. Many communities in this and other states have accepted the advice of their medical societies, dental societies, health departments, and other reputable groups, and are fluoridating drinking water.

4. No new scientific evidence has been presented to indicate that this or any other society should change its stand on this matter.

5. To pass this resolution at this time, without such evidence, would be extremely unwise.

Therefore, Mr. Speaker, I move the rejection of this resolution.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried, with E. G. M. Krieg, M.D., voting "no.")

XII—9(c). RESOLUTION RE POLLUTION OF INLAND WATERWAYS

O. K. ENGELKE: This resolution was changed in one or two phrases, which in no way alter its original content. In the opinion of the Reference Committee and our advisers, it makes the resolution more worthwhile to the citizens of the State as well as to this Society. I will read the proposed change:

"Whereas, the State Department of Conservation has improved recreational facilities by purchase of waterfront land and has opened inland waterways and lakes, making these waterways accessible to our citizens, including owners of large boats, and

"Whereas, pollution and desecration of Michigan inland waterways and lakes may therefore occur by insanitary disposal of human and other wastes; therefore, be it

"RESOLVED: That the Michigan State Medical Society urge the Department of Conservation to investigate this situation and take proper steps to eliminate any problem which may be disclosed."

Mr. Speaker, I move adoption of this resolution.

L. R. LEADER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

O. K. ENGELKE, M.D.: I move acceptance of this report as a whole.

E. G. M. KRIEG, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—10. ON MISCELLANEOUS BUSINESS RE SPEEDY RECOVERY OF PRESIDENT EISENHOWER

XII—10(d). RESOLUTION

G. S. BATES, M.D.: The Reference Committee approves this resolution, and I move adoption of the report of the Reference Committee.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

XII—7. ON SPECIAL MEMBERSHIPS

C. K. STROUP, M.D.: Your Reference Committee wishes to facilitate and expedite this procedure, and has listed the doctors whom we recommend as eligible for *life membership* by county societies. I shall read the names.

Life Membership

Bay County: Aloysius J. Zaremba, M.D., Bay City.

Branch County: Kendall B. Rees, M.D., Coldwater.

Dickinson-Iron County: George H. Boyce, M.D., Iron Mountain.

Genesee County: Clifford P. Clark, M.D., Coral Gables, Florida; Lafon Jones, M.D., Flint; Edwin E. Miller, M.D., Flint.

Ionia-Montcalm County: Robert H. Haskell, M.D., Northville; Lee E. Kelsey, M.D., Lakeview; Isaac S. Lilly, M.D., Stanton.

Jackson County: Edward W. Douglas, M.D., Jackson; Walter L. Finton, M.D., Jackson; Frank F. Pray, Jackson.

Kalamazoo County: Dirk J. Scholten, M.D., Kalamazoo.

Menominee County: Henry T. Sethney, M.D., Menominee.

Midland County: Joseph H. Sherk, M.D., Midland.

St. Joseph County: Charles G. Miller, M.D., Sturgis.

Washtenaw County: Howard H. Cummings, M.D., Ann Arbor; Warren E. Forsythe, M.D., Ann Arbor; Christopher G. Parnall, M.D., Ann Arbor; Inez R. Wisdom, M.D., Ann Arbor.

Wayne County: Alexander W. Blain, M.D., Detroit; Frederick H. Cole, M.D., Detroit; William A. Defnet, M.D., Detroit; Martin S. Dubpernell, M.D., Detroit; Samuel Glassman, M.D., Detroit; Fred L. Honhart, M.D., Detroit; Charles J. Jentgen, M.D., Detroit; E. V. Joinville, M.D., Detroit; George M. Laning, M.D., Detroit; Elbert A. Martin, M.D., Detroit; William O. Merrill, M.D., Detroit; Plinn F. Morse, M.D., Detroit; Fred W. Organ, M.D., Detroit; John B. Rieger, M.D., Detroit; Susanne M. Sanderson, M.D., Detroit.

The Reference Committee recommends that these doctors be elected to life membership, and I so move.

R. W. TEED, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

C. K. STROUP, M.D.: The following doctors have been passed by your Reference Committee as eligible for *retired membership.*

Retired Membership

Bay County: Edward S. Huckins, M.D., Bay City.

Calhoun County: Theodore Kolvoord, M.D., Battle Creek.

Delta-Schoolcraft: John J. Walch, M.D., Escanaba.

Wayne County: John R. Boland, M.D., Detroit; Jerome W. Ankley, M.D., Detroit; Ray D. Schirack, M.D., Detroit; Bertrand C. Switzer, M.D., Detroit.

C. K. STROUP, M.D. (continuing): Mr. Speaker, I move that these men be elected to retired membership.

J. B. BLODGETT, M.D.: Second.

(The motion was put to a vote and was carried unanimously.)

C. K. STROUP, M.D.: The following doctors have been passed by your Reference Committee as eligible for *associate membership.*

Associate Membership

Delta-Schoolcraft County: Gilbert W. Benson, M.D., Escanaba.

Eaton County: Richard K. Meinke, M.D., Rochester, Minnesota.

Muskegon County: Robert G. Heneveld, M.D., Muskegon.

Wayne County: Henry A. Archambault, M.D., Detroit; Dorothy Fisher Caton, M.D., Detroit; Charles M. Ebner, M.D., Detroit; Martin Z. Feldstein, M.D., Detroit; Dunbar P. Gibson, M.D., Detroit; Gene L. Hackleman, M.D., Dearborn; Ralph G. Hubbard, M.D., Detroit; Werner K. Kersten, M.D., Detroit; Francine Larson, M.D., Wyandotte; Nur M. Malik, M.D., India; Charles W. Park, M.D., Detroit; Eugene V. Perrin, M.D., Washington, D. C.; Jack C. Smith, M.D., Detroit; Vincent J. Turcotte, M.D., Detroit.

C. K. STROUP, M.D. (continuing): Mr. Speaker, I move that these doctors be so elected.

F. P. RHOADES, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

C. K. STROUP, M.D.: I move that the report of the Reference Committee be accepted as a whole.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

XII—11. ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

XII—11(a). RESOLUTION RE STUDY OF SURGICAL FEES (MMS)

J. M. WELLMAN, M.D.: Resolution No. 23, introduced by H. W. Harris, M.D., of Ingham County, relative to some inequities in the surgical fee schedules of Michigan Medical Service. I will read the "Resolved" in the original resolution:

"RESOLVED: That a committee composed of a representative group of physicians of Michigan, including persons from the so-called surgical specialties, be appointed and directed to study the entire surgical fee schedule, with a view to correction of the abovementioned, and any other inequities found in such study; and that this committee be directed to report its findings and recommendations to Dr. Hull's Committee on the Study of the Fee Schedules of the Michigan Medical Service at a time to be determined by the Chairman of that Committee."

Your Reference Committeee had the benefit of discussing this resolution with its sponsor, and endorses the statement embodied in the preamble. In view of the fact that there has very recently been appointed the Study Committee on Fee Schedules for Michigan Medical Service, your Reference Committee does not concur that a separate new committee be appointed, and recommends that the "Resolved" portion of the above resolution be changed to read as follows:

"RESOLVED: That the recently appointed Study Committee on Fee Schedules for Michigan Medical Service be directed to review the entire surgical fee schedules with a view to correction of the abovementioned and any other inequities found in its study."

Mr. Speaker, I move the adoption of this substitute resolution.

J. B. BLODGETT, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—11(b). RESOLUTION RE COMMITTEE ON DIVISION OF FEES (MMS)

DR. WELLMAN, M.D.: We shall re-read the Resolution as introduced:

WHEREAS, the Board of Directors of Michigan Medical Service has adopted the recommendations of the Special Committee of the Board of Directors of Michigan Medical Service, to divide the scheduled fee of Michigan Medical Service between physicians, and

WHEREAS, both the Committee and Board of Directors of Michigan Medical Service have recommended that Michigan State Medical Society develop the methods of implementation of this procedure; therefore be it

RESOLVED: That the President of the Michigan State Medical Society appoint a committee to formulate this procedure, and when the methods are approved by The Council of the Michigan State Medical Society they be transmitted to Michigan Medical Service, to be made effective; and be it further

RESOLVED: That due consideration shall be given to the ethical, legal and administrative and other phases involved.

J. M. WELLMAN, M.D.: Your reference Committee approves of this resolution, but recommends that the procedures and methods developed by the Committee mentioned by the resolution be limited in their application to those instances specifically designated in the original resolution on this matter, adopted by the House of Delegates in September, 1954, as follows:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to Michigan Medical Service that it develop procedures to pay surgical fees to the operating surgeon and the assisting physician who has actually and in person assisted at the surgical operation on the patient."

Mr. Speaker, I move adoption of this portion of the report.

E. A. BICKNELL, M.D.: Second the motion.

O. J. JOHNSON, M.D.: I move that the recommendation of the Reference Committee, to restrict the division of fees to surgical fees only, be rejected, and that the original content of the resolution, which says a division of scheduled fees, stand.

(The amendment was put to a vote and was carried, but not unanimously.)

THE SPEAKER: We are now back to the main motion, to approve the resolution as amended by the Reference Committee. Are you ready for the question on the motion? The motion is to approve. All those in favor will say "aye"; opposed, "no." The motion is carried.

J. M. WELLMAN, M.D.: Mr. Speaker, I move approval of this report of the Reference Committee as a whole, as amended.

L. R. LEADER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

We will recess until 8 p.m.

(The meeting recessed at 12:30 p.m.)

TUESDAY EVENING SESSION
September 27, 1955

The final session of the House of Delegates convened at 8:25 p.m., J. E. Livesay, M.D., Speaker of the House, presiding.

XII—11(c). RESOLUTION RE BLUE SHIELD REPORTING IN MEDIATION CASES.

J. M. WELLMAN, M.D.: Your Reference Committee on Medical Service and Prepayment Insurance is bringing up for the first time the third resolution which was referred to it. This Reference Committee considered a resolution re Blue Shield reporting in mediation cases. Your Reference Committee considered this resolution in great detail. It heartily endorses the four preambles which are stated therein. Your Reference Committee furthermore disapproves the "Resolved" portion of the resolution, and submits the following substitute resolution:

(See Page 1504 for Preamble.)

"RESOLVED: That the Blue Shield organization, upon receipt of any letters or communications alleging abuse, which are outside the province of the present liaison committee between the Michigan State Medical Society and Blue Shield, be advised to communicate with the complainants, suggesting that they should submit their complaint directly to the local county medical society."

Mr. Speaker, your Reference Committee recommends the adoption of this substitute resolution, and I so move.

A. E. SCHILLER, M.D.: Second the motion.

RUSSELL FENTON, M.D.: I would like to amend the motion **that all complaints not handled by the Liaison Committee will be referred by Michigan Medical Service back to the county medical society, and a letter is to be sent to the complainant informing him of the disposition by them of his complaint.**

L. R. LEADER, M.D.: Second the motion.

THE SPEAKER: We are voting now on the amendment. All those in favor of approving the amendment will say "aye"; opposed, "no."

The Chair will ask for a show of hands. Those in favor, raise your hands. (56). Those voting "no," raise your hands. (30).

The motion is carried.

Now that the amendment is adopted, the parliamentary procedure is to vote on the main motion as amended. Is there any further discussion? All those in favor say "aye"; opposed, "no." It is carried.

J. M. WELLMAN, M.D.: I move the adoption of the

report of the Reference Committee as a whole, as amended.

OTTO VAN DER VELDE, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

XIV. ELECTIONS

THE SPEAKER: The floor is now open for nominations for Councilors from the 2nd District. The incumbent is R. S. Breakey, M.D. of Lansing.

XIV—1. COUNCILOR, 2nd DISTRICT

A. W. STROM, M.D.: I would like to take this opportunity, before making a nomination, to thank Dr. Robert Breakey for serving as Councilor in our District for the past five years. Dr. Breakey does not wish to be a candidate for re-election.

I should like to nominate a man well known to the members of the House of Delegates. He has served as a delegate from Ingham County for seven years. He is a Past President of the Ingham County Medical Society. He has served on several State Medical Society committees.

Dr. Oliver B. McGillicuddy.

THE SPEAKER: Dr. McGillicuddy of Lansing has been nominated.

F. L. TROOST, M.D.: As a colleague of Dr. McGillicuddy's for about twenty-five years, during which time we have been associated on both Lansing hospital staffs and associated as delegates and as members of many county society committees, I would like to second Dr. McGillicuddy's nomination. I am sure that he will be a credit to our District and an asset to The Council.

THE SPEAKER: Are there any further nominations for Councilor from the 2nd District?

C. K. HASLEY, M.D.: Mr. Speaker, I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. McGillicuddy.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

THE SPEAKER: Dr. McGillicuddy is declared elected.

XIV—2. COUNCILLOR, 3rd DISTRICT

Nominations are now open for Councilor from the 3rd District. Dr. George W. Slagle of Battle Creek is the incumbent.

H. J. MEIER, M.D. (Branch): I could say many nice things about the doctor whom I would like to place in nomination; at least no bad things. Suffice it to say that we had a small caucus at a table for four, and we decided we were very happy with the work that Dr. Slagle has done for us in the 3rd District. The delegates from that District would like to place Dr. Slagle's name in nomination for Councilor from the 3rd District to succeed himself.

H. C. HANSEN, M.D. (Calhoun): It certainly gives me a great deal of pleasure to usher in our candidate from our District, to carry on in the same fashion that he is so well capable of doing.

THE SPEAKER: Are there further nominations?

S. A. FIEGEL, M.D. (St. Joseph): I am most happy also to second George Slagle's nomination.

I would like to move that nominations be closed, and that the Secretary be instructed to cast the unanimous ballot in favor of Dr. Slagle.

OTTO O. BECK, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. Slagle is declared re-elected.

XIV—3. COUNCILOR, 15th DISTRICT

Councilor for the 15th District. The incumbent is D. Bruce Wiley, M.D., of Utica. The floor is open for nominations.

SYDNEY SCHER, M.D. (Macomb): It is my pleasure to place before this House the name of a doctor for nomination and re-election as Councilor for the 15th District.

Dr. D. Bruce Wiley has practiced in Macomb County for twenty-six years, and is a highly respected general practitioner. He has served as Secretary of his County Medical Society for ten years. He is a Past President of his County Medical Society and has been a delegate in this House for ten years, and for the last five years he has served diligently and faithfully as Councilor for the 15th District.

We in the 15th District are very happy to support Bruce, who served us so faithfully and efficiently, and we see no reason to make a change. I take great pleasure in nominating Bruce Wiley for re-election as Councilor for the 15th District.

H. A. FURLONG, M.D.: Mr. Speaker, for the past five years we have enjoyed very much being associated with Dr. Wiley in Oakland County. He has been a wise Councilor in every sense of the word. We would like very much to have him continue in the office he has held. Oakland County's delegates are very proud to second his nomination.

N. F. GEHRINGER, M.D.: I would like at this time to say that we are very well satisfied with Bruce Wiley's work, and I would like to move that nominations be closed and that the Secretary cast the unanimous ballot for Dr. Wiley.

OTTO O. BECK, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. D. Bruce Wiley is declared re-elected.

XIV—4. COUNCILOR, 16th DISTRICT

Councilor for the 16th District. Dr. G. T. McKean, M.D., Detroit, is the incumbent. The floor is open for nominations.

J. J. LIGHTBODY, M.D. (Wayne): Several months ago Dr. McKean was appointed by The Council of the Michigan State Medical Society to succeed Dr. Barrett, who resigned as Councilor of the 16th District. This appointment by The Council was a very happy one, and the delegates from our County have been very pleased with the appointment.

I think Dr. McKean might be considered one of the younger men in this group. He has been very active in his County Society, and much more so recently in the State Society. He has been a very welcome addition to The Council, we understand, and it is my privilege to nominate Dr. Tom McKean as Councilor for the 16th District to succeed himself.

M. A. DARLING, M.D.: It gives the Wayne delegation a great deal of pleasure, and me in particular, to have the honor of seconding the nomination of G. Thomas McKean as Councilor for the 16th District.

L. R. LEADER, M.D.: Mr. Speaker, I make a motion that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Thomas McKean.

J. J. LIGHTBODY, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. McKean is declared re-elected.

XIV—5. DELEGATES TO AMA

The next item of business is the election of delegates to the AMA. Once again I call your attention to the fact that the name of W. D. Barrett, M.D., appears in error in the program. It should be the name of J. S. DeTar, M.D., and W. A. Hyland, M.D., and R. A.

Johnson, M.D. I have a letter from Jack DeTar, who is not with us at this meeting. He is at the University of Tennessee making some speeches.

The floor is now open for nominations.

(Drs. J. S. DeTar, Wm. A. Hyland and C. I. Owen were nominated.)

S. L. LOUPEE, M.D.: I wish to move that nominations be closed and that the Secretary cast a unanimous ballot.

O. K. ENGELKE, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: I declare Drs. DeTar, Hyland and Owen elected.

XIV—6. ALTERNATE DELEGATES TO AMA

(Drs. E. F. Sladek, W. W. Babcock and O. J. Johnson were nominated. Subsequently the Speaker declared the election as balloted in this order: Babcock, Sladek, Johnson.)

J. J. LIGHTBODY, M.D.: Mr. Speaker, I arise for a point of information. Dr. Owen, who was an alternate delegate, has now been elected to be a delegate. That then gives us another vacancy. I think there is one year left in Dr. Owen's term, so is it proper now to continue nominations in this particular way? Three of these individuals who are up for re-election are two-year terms. The man who would replace Dr. Owen would serve for one year.

(Dr. Wm. Bromme, Detroit, was nominated and elected.)

XIV—7. PRESIDENT-ELECT

C. E. UMPHREY, M.D. (Wayne): It has been my privilege over the last twenty years to appear before you many times. Unfortunately, quite frequently there was a controversy. Tonight I am happy to say I do not believe there will be any controversy.

I am in a position tonight that almost any member of my delegation would give his eye teeth to be in. I am about to present the name of a man who has served us well on the local front. He has been a member of almost every committee that we have, both as committeeman and as chairman. He has been President of the Wayne County Medical Society. This pretty well takes care of the local front.

He has represented you on the State front. He has been on your State Council. He has been on the Public Relations Committee and many other committees. So, he is well qualified to carry on and do the job that we would like to have done.

I once heard him described as a big man both physically and mentally, and somebody said he was six foot four in his stocking feet all stooped over.

It gives me a great deal of pleasure tonight to mention a confrere who has been one of my keenest competitors locally, and in fact has made it very difficult for me in the practice of medicine; but I love him for it.

I give you the name of Arch Walls, M.D.

E. A. OAKES, M.D. (Manistee): Mr. Speaker and gentlemen of the House, I want to say that Arch Walls still owes me a buck in a game of golf. Fifteen years ago we played a game in Owosso. I don't forgive him. I have known him for a good many years and have worked with him a lot. I don't know a better man to represent us as President of the State Society than Arch Walls. He is a real thinking man. I am very happy to stand here and second the nomination of Arch Walls.

Thank you.

F. P. RHOADES, M.D.: I would like to move that nominations be closed, and that the House cast a unanimous ballot for Dr. Arch Walls as President-elect.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

THE SPEAKER: Dr. Walls is declared elected. Will President Baker and President-elect Jones please escort our new President-elect to the rostrum?

ARCH WALLS, M.D.: Mr. Speaker and Members of the House of Delegates:

First of all, I want to thank Dr. Umphrey for all those kind and generous words, and secondly I thank these gentlemen for the help I have had in getting up here.

I feel very humble tonight in accepting the honor that you have just bestowed upon me. I feel that it is a great honor to be placed in the position of President-elect of such a wonderful and highly recognized Society as the one we have in the Michigan State Medical Society.

Along with this responsibility, I appreciate that there are many responsibilities, and I hope I will be able to carry them out. I also realize there are many decisions that have to be made, but I am sure I will be patient and let The Council decide for me, as usual.

There are a great many things I would like to say tonight, but during the year to come and the next year, when I will take office, I hope to create a more splendid union between our profession so that there will be less publicity in the press—less criticism. I think that can be done.

I feel that probably in two years' time I will be developing a somewhat Southern brogue in my close association with my good friend, your President at the present time. I wish now to take the opportunity of resigning as a Councilor from the 1st District of the Michigan State Medical Society.

Again I want to thank you all from the bottom of my heart for this great honor that you have bestowed upon me.

Thank you.

XIV—8. COUNCILOR, 1st DISTRICT

THE SPEAKER: The next item of business is to elect a Councilor for the 1st District to fill the one-year unexpired term of Dr. Walls.

(A. E. Schiller, M.D., Detroit, was nominated and elected.)

XIV—9. SPEAKER OF THE HOUSE

VICE SPEAKER JOHNSON: Nominations are now in order for Speaker of the House of Delegates.

F. D. JOHNSON, M.D.: Up in Flint we rely a great deal upon a man who gives us sagacious and unemotional opinions. We often give our Board's serious problems to him to help solve. We are proud of him. However, in the interest of the Michigan State Medical Society, both Genesee County and his wife are willing to loan him to the Society for another year.

I wish to place in nomination, for Speaker of the House, the name of Dr. Jackson Livesay.

CHAIRMAN JOHNSON: Are there further nominations? Dr. Livesay has been nominated.

C. W. OAKES, M.D.: I have the pleasure of moving that nominations be closed and that the ballot be cast for Dr. Livesay.

OTTO O. BECK, M.D.: I second that motion.

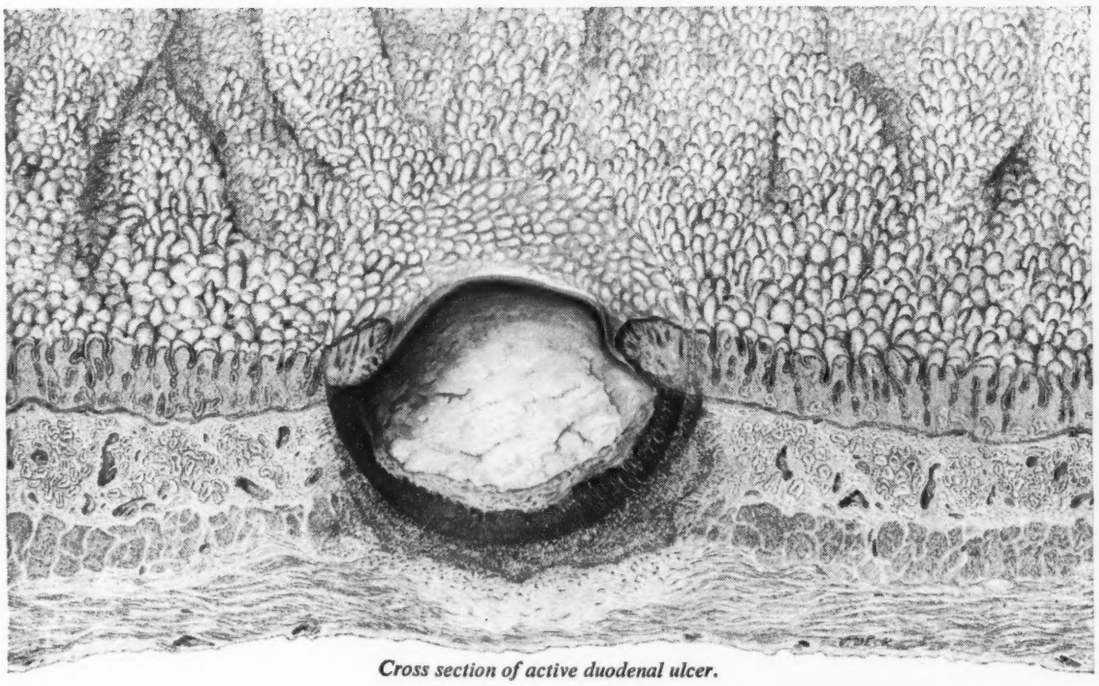
(The motion was put to a vote and was carried unanimously.)

CHAIRMAN JOHNSON: Dr. Livesay, congratulations!

(The Speaker resumed the Chair.)

THE SPEAKER: Thank you, Dr. Johnson, for your very nice remarks, and for intimating that I allowed myself to be placed in this position rather reluctantly due to the press of other business. Thank you, gentlemen. I pledge myself to continue to be your humble servant.

(Continued on Page 1540)



Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthīne.

"In studying[1] the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

". . . our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility. . . .

"Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy[2] Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors[2] is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

SEARLE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

PREVIEW OF BUDGET FOR HEALTH DEPARTMENT

A preview of the budget that will be submitted by the Michigan Department of Health to the 1956 Legislature highlights the problems faced by the department in attempting to meet the snowballing requests for service.

The requested addition of twenty-five staff members does not represent new activities. It holds the line, reinforcing current services that are carrying the heaviest pressure.

The state's changing public health needs to which the budget is geared are due largely to our rapidly growing population—heavily weighted with the young and the old—to industrial developments that make undreamed of demands upon water supplies and waste disposal systems, and to the shift from urban to suburban living that brings in its wake a whole train of variations upon old problems of sanitation.

The department's division of engineering, with its requested increase of eleven persons, typifies the present situation. The staff, ten years ago, by spreading itself thin, could fulfill the legal requirement that the department review and approve plans and specifications for public water supply systems, public sewerage systems and public swimming pools. In addition, they gave a degree of consultant service on environmental sanitation.

The same staff, today, is unable to keep up with the mounting requests for permits for new and expanded water systems and sewage disposal facilities, much less to give the close supervision that is so important in keeping intricate modern systems operating properly. Consultant services to local health departments and state agencies have increased, as has emergency service to the thirteen counties without health departments, assistance in resort sanitation, and the task of licensing trailer parks.

The problem is not only to keep up with the examination and approval of plans from municipalities, with city councils, architects and construction firms waiting impatiently to proceed. Even more time consuming and exacting is the task of field consultation, where it picks up to help guard against the horse and buggy thinking that solves the problem of a new subdivision by simply adding water mains, without considering whether yesterday's filtration plant and feeder mains can carry the load.

An equally difficult hurdle is helping to change the feeling in almost every community that it is a law unto itself in water supply and waste disposal. If we are to have the ample water supplies and the adequate waste disposal that present day living and industry require we must have area thinking, not piecemeal approaches.

All this demands the guidance that can be given only by a trained and experienced staff.

In the metropolitan district particularly, local health departments face some of their stiffest problems and have their greatest need for consultant help in handling the fringe areas. Community sanitation facilities are inadequate or non-existent and a hodgepodge of individual and group systems makes supervision extremely difficult.

Increased school health services made necessary by the jump in school enrollments account for the items in the requested budget of an additional vision technician, an added hearing technician and a nutritionist. The department works with local agencies in these services, supplementing local health department staffs and equipment and providing the inservice training needed to keep the programs up to high standard.

The budget for occupational health carries a few minor increases, including an additional clerk.

The department budget carries, as usual, an item for a physician on Beaver Island.

The amount asked for hospital licensure and certification is approximately the same as that in last year's budget, with the addition of a nurse and a dietitian.

The item for venereal disease control is the same as last year, with no change in program or services.

Tuberculosis control continues to dominate the budget. A new item this year provides for subsidizing outpatient care services. Another item provides assistance to general hospitals in reporting chest x-rays of persons admitted. A fee of 50 cents is proposed for each chest x-ray reported. A third new item provides for grants to local health departments for improved casefinding and case holding, including tuberculin testing.

Program emphasis in chronic disease control will continue to focus on the collecting and analyzing of information, with special attention to methods of casefinding and prevention and to consultation to nursing and convalescent homes. A diabetes testing pilot study is planned, together with continuation of the study of screening for cancer of the cervix, teaching clinics in chronic diseases for physicians and a local demonstration of home care for the chronically ill patient.

Requested grants for local health services are increased from the $325,000 appropriated last year to $600,000 this year. The money is distributed to local health departments according to a formula set up by Act 187, P.A. 1954. The grants have two purposes. One is to provide greater incentive for the thirteen counties now without full-time health departments to establish them. The second is to assist in the maintenance of services in existing local health departments, particularly in environmetal health, problems of the chronically ill and aging and preventive mental health.

In Memoriam

Glenn R. Backus, M.D., Flint, staff pathologist at Hurley, McLaren, and St. Joseph Hospitals, was a graduate of the University of Michigan Medical School, 1930, and served his internship and residency at Hurley Hospital in Flint. He was a member of the American Board of Pathology, a past president of the Michigan Pathological Society, and a Fellow of the College of American Pathologists and the American Society of Clinical Pathologists. In World War II, he served as head of the pathological laboratories at McKinney Field, Texas. He was also stationed at Wm. Beaumont Hospital, El Paso, Texas. He was born on August 16, 1906, at Calumet; he died September 5, 1955.

* * *

Wm. E. Barstow, M.D., of St. Louis, who served his native Gratiot County for more than fifty years as a practicing physician, died October 6 in Detroit, where he had been taken for treatment of complications following a heart attack last August. He was seventy-eight years old.

Dr. Barstow was President of MSMS in 1949-50, and well known and beloved throughout the state. He also served as President of the Gratiot-Isabella-Clare County Medical Society.

In addition to his leadership in MSMS affairs, Dr. Barstow was a community leader. He was a charter member and past president of the St. Louis Rotary Club and past president of the St. Louis School Board, upon which he served for many years. He devoted thirty years of active service to Boy Scout work and was awarded the Silver Beaver Award, one of the highest honors in scouting.

Dr. Barstow was born in North Star Township, Gratiot County, September 15, 1877. He was graduated from Ithaca High School and the University of Michigan Medical School, receiving his M.D. degree in 1905. He established his practice in St. Louis, immediately following graduation, and remained there.

At the 1955 Annual Session in Grand Rapids, Dr. Barstow was inducted into the MSMS "Fifty-Year Club." Unable to attend, his insignia was accepted by his daughter, Mrs. Harold Gay, of Midland, wife of an MSMS member.

Dr. Barstow is survived by his widow, Mary Belle; two sons, Donald K. Barstow, M.D., who was in practice with his father; and William Barstow, of Dearborn, and his daughter, Mrs. Gay.

* * *

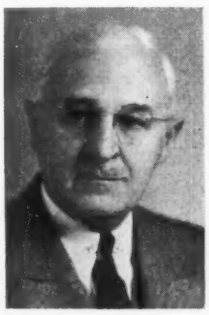
A. James DeNike, M.D., Detroit, born May 4, 1875, at Belleville, Ontario, attended Rush Medical College, Chicago, and Grand Rapids Medical School, graduating in 1903. He practiced at Whitehall, Michigan, and Clinton, New York, before moving in 1923 to Detroit, where he specialized in neuropsychiatry and rehabilita-

tion of alcoholics and drug addicts. Dr. DeNike was owner and medical superintendent of a private sanitarium. He was elected to MSMS Fifty-Year Club in 1953, and to MSMS emeritus membership. He died while vacationing at Scottsdale, Arizona, February 17, 1955.

* * *

Walter D. Ford, M.D., Dearborn, Emeritus member of MSMS, was a graduate of Wayne University College of Medicine, 1899. He interned at Harper Hospital and was a resident in German and English hospitals. Dr. Ford served in the Medical Corps during World War I, attaining the rank of Major. He died October 11, 1955, at the age of seventy-seven.

* * *



Henry A. Luce, M.D., of Detroit, who recently celebrated his fiftieth anniversary as a doctor of medicine, died October 28, 1955, in Detroit following an illness of three weeks.

Nationally known for his work in the field of psychiatry, Dr. Luce was held in high esteem by all members of his profession and by the public for his many years of devoted service to Medicine.

An outstanding and nationally known leader in medical organization, Dr. Luce was State Society President in 1938-39, President of Wayne County Medical Society in 1925-26 and a Michigan Delegate to the American Medical Association for eighteen years. He was also a Past President of the Michigan Society of Neurology and Psychiatry, a former Advisor to the Michigan Society of Mental Hygiene, and an Honorary Member of the American Academy of General Practice.

In recent years, Dr. Luce has been intensely interested in training more practitioners in various phases of psychiatry to alleviate the increasing burdens on those M.D.'s limiting themselves to this branch of medicine.

Dr. Luce was a staff member of the following hospitals: Deaconess Evangelical, Harper, Jennings, Receiving, and Wayne County General.

Born on a farm near Fenton, Michigan, in 1874, Dr. Luce was graduated in 1905 from the Detroit College of Medicine and Surgery, now Wayne University College of Medicine.

Dr. Luce is survived by his widow, Stella and a daughter, Mrs. Susan Martin.

* * *

George H. Wood, M.D., Onaway, was born in Charlevoix, March 18, 1874. He graduated from Saginaw Valley Medical College and began practice in Alanson in 1901. He practiced in Onaway and Reed City prior to 1949, then in Detroit for several years, before returning to Onaway. An ardent student of constitutional government, he was the author of several articles on that subject. Dr. Wood died suddenly September 16, 1955, in Lansing while on a business trip.

Communications

Mr. William J. Burns
Executive Director
Michigan State Medical Society
Lansing, Michigan

Dear Mr. Burns:

During part of August and September last, it was the privilege of the writer and his wife and youngest son to spend vacation time in the Upper Peninsula of your fair State of Michigan—as has been our custom for the past several years.

Almost from the time of our arrival at the resort and for the first ten days or so, our son, who is in his nineteenth year, was quite seriously ill with an upper respiratory infection, attributable to an acute sinus condition. We, of course, were not immediately cognizant of the reason for the illness and, needless to say, were quite concerned since the symptoms were very indicative of polio.

After attempting without too much success, to enlist the services of a doctor "vacationing" at the same resort, my wife suggested that she call our family physician from a pharmacy in ..... some twenty odd miles from camp—to prescribe to pharmacist for our son. The pharmacist convinced her that it would be poor policy to try to diagnose by phone, even though he would be willing to abide by doctor's orders. My wife rather reluctantly agreed, stating that we were utter strangers and knew of no doctor in the vicinity who would be willing to offer his services, especially so far from town. Whereupon the pharmacist very obligingly stated that he would engage the services of a doctor for us. For this, we will be forever grateful.

That same evening, less than a half hour after my wife's arrival back at camp, a Doctor ..... of ..... was attending our son. His diagnosis of our son Bruce's illness was completed and he assured us that it was not polio but that we had cause for alarm. He administered 600,000 units of penicillin and left other medication and prescriptions and suggested that we bring Bruce to his office in a few days or as soon as Bruce was able to travel comfortably. I learned later that the doctor had made the trip after just having completed an appendectomy.

It was necessary for us to visit the doctor's office for further treatment three or four times during the remainder of our vacation, during which time we had plenty of time to observe that some doctors still believe in the Oath they took upon entering practice. We were especially impressed by the co-operation between those connected with the profession. All of this seems so different from what we have come to know in more urban communities.

We merely want you to know that we are very grateful for services such as rendered by Dr ....., the pharmacist (whose name I neglected to learn), and the others who were so genuinely concerned. This has been the main purpose of my writing this letter and to say that our faith in the medical profession has been firmly re-established.

Some people are too eager to criticize a doctor when things do not go well, and so reluctant to commend when experiencing a situation like ours, that I believe a little "pat on the back" might do some good. My wife Muriel and son Bruce concur in my belief.

Sincerely,
FORREST A. RANK

103 So. Cornell Ave.,
Villa Park, Illinois
Sepember 28, 1955

P.S. You may be interested in knowing that the name of your Organization and address was furnished to me by ..... of the American Society of Anesthesiologists, and our good neighbor. However, it must be understood that this is not a solicited testimonial—but entirely my own thoughts and written at my own volition.

Wilfrid Haughey, M.D., Editor
Michigan State Medical Society Journal
Battle Creek, Michigan

Dear Sir:

The Beaumont Memorial Fund's need for more money was discussed at our County Society's September meeting. A canvass of the members revealed that all had contributed, some quite generously. All were agreed that this project deserved more support. It was unanimously decided that each member be assessed $5.00. Accordingly we are sending $105.00 to the Beaumont Fund.

Sincerely,
HARVEY L. MOSS, M.D.
Secretary-Treasurer
Branch County Medical Society

Coldwater, Michigan
October 14, 1955

When little patients balk at scary, disquieting examinations (before you've begun) . . .

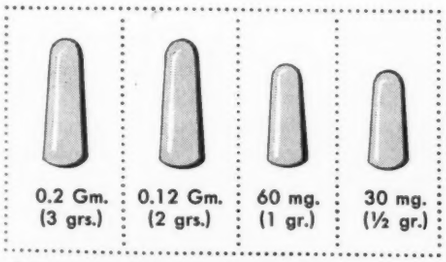
When they're frightened and tense (and growing more fearful by the minute) . . .

When they need prompt sedation (and the oral route isn't feasible) . . . try

NEMBUTAL®

Sodium Suppositories

With short-acting NEMBUTAL, the dosage required is small and the margin of safety is wide. And—since the drug is quickly and completely destroyed in the body—there is little tendency toward morning-after hangover. Keep a supply of all four sizes of NEMBUTAL suppositories on hand. Be ready for the frightened ones before their fears begin. Abbott



® Pentobarbital Sodium, Abbott

512131

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

Noah E. Aronstam, M.D., Detroit, is the author of an article entitled "The Treatment of Occupational or Erg Dermatoses with Titanium Oxide" which was published in the *Indian Journal of Dermatology and Venereology,* April-June, 1955.

Martin J. Urist, M.D., South Haven, is the author of an article entitled, "Eccentric Fixation in Amblyopia Ex Anopsia," published in AMA *Archives of Ophthalmology,* September, 1955.

Charles I. Cerney, M.D., and **Robert B. Wallace, M.D.,** Detroit, are the authors of an article entitled "Carcinoma of the Pancreas: A Review of 160 Cases," published in *The American Practitioner and Digest of Treatment,* September, 1955.

Murray R. Abell, M.D., Ann Arbor, is the author of an article entitled "Diseases of the Gallbladder: Their Nature and Classification," published in the *Canadian Medical Association Journal.* A condensation of this paper appeared in the *American Practitioner* and *Digest of Treatment,* September, 1955.

B. E. Brush, M.D., W. E. Chase, M.D., and **M. A. Block, M.D.,** Detroit, are the authors of an article entitled "An Evaluation of Newer Methods in the Diagnosis of Hyperparathyroidism," read at the twelfth annual meeting of the Central Surgical Association, Chicago, February 18, 1955, and published in AMA *Archives of Surgery,* September, 1955.

Robert D. Swedenburg, M.D., William M. Tuttle, M.D., and **K. E. Corrigan, Ph.D.,** of Detroit, are the authors of an article entitled "Isotype Techniques for Mediastinal Tumors," read at the twelfth annual meeting of the Central Surgical Association, Chicago, February 18, 1955, and published in the AMA *Archives of Surgery,* September, 1955.

Robert E. L. Berry, M.D., and **C. Thomas Flotte, M.D.,** Ann Arbor, are the authors of an article entitled "Peripheral Arteriosclerotic Vascular Disease in Diabetes," read at the twelfth annual meeting of the Central Surgical Association, Chicago, February 18, 1955, and published in AMA *Archives of Surgery,* September, 1955.

Prescott Jordan, Jr., M.D., and **James Wible, M.D.,** Detroit, are the authors of an article entitled "Spring Valve for Mitral Insufficiency" read at the twelfth annual meeting of the Central Surgical Association, Chicago, February 18, 1955, and published in AMA *Archives of Surgery,* September, 1955.

Paul W. Pifer, M.D., Melvin Block, M.D., and **C. Paul Hodgkinson, M.D.,** Detroit, are the authors of an article entitled "Experimental Hypofibrinogenemia," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

William C. Noshay, M.D., Detroit, is the author of an article entitled "The Treatment and Employability of the Epileptic," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

William E. Chase, M.D., Detroit, is the author of an article entitled "An Evaluation of Radical Perineal Prostatectomy for Carcinoma," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

J. Dana Darnley, M.D., Detroit, is the author of an article entitled "Diastematomyelia: A Treatable Lesion In Infancy and Childhood with Case Report," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

L. A. Swinehart, M.D., Detroit, is the author of an article entitled "Clinical Evaluation of Chlorpromazine Hydrochloride in Acute Nausea and Vomiting," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

Claribel Westermeyer, M.D., Detroit, is the author of an article entitled "Ulcer Symptoms Due to Schistosomiasis Mansoni," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

Brock E. Brush, M.D., William L. Lowrie, M.D., Earl Redfern, M.D., and Wayne Hollinger, M.D., Detroit, are the authors of an article entitled "Hyperinsulinism," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

Robert J. Fetz, M.D., Detroit, is the author of an article entitled "The Prognosis in Cancer of the Kidney," published in the *Henry Ford Hospital Medical Bulletin,* September, 1955.

* * *

American Board of Obstetrics and Gynecology.—The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 3, 1956.

Case abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

* * *

Fourth Annual Trauma Symposium.—More than 270 physicians attended the Fourth Annual Trauma Symposium at Wayne University's College of Medicine, Wednesday, November 9, 1955.

The day-long conference is sponsored by the Michigan

(Continued on Page 1528)

After Bread Comes Wine...

*The Second Legacy of the Creator**

From the very dawn of history, wine, the classic beverage of moderation, has been acclaimed for its appetite-stimulant properties, its role in nutrition, its function as an aperitif.

However, until quite recently no serious attempt was made at a scientific objective study of the rationale of wine as a nutritional or medicinal agent.

Recently, in response to a demand within the medical profession that fact be separated from folklore, the Wine Advisory Board decided to institute a series of studies to determine the true therapeutic niche of wine based on a more accurate knowledge of its chemical constituents, its physiological and pharmacological actions.

The results to date have been most gratifying. For example, we have learned that—

—Wine stimulates olfactory acuity—markedly increasing appetite in anorexia;

—Wine increases appreciably not only the volume but the proteolytic power of gastric juice, thereby encouraging digestion notably in convalescents and older patients;

—Wine serves as a quick-energy food. Its small amount of hexose is speedily absorbed and its moderate content of alcohol is metabolized readily even by diabetics;

—Wine possesses significant vasodilating, diuretic and relaxing properties of value in the field of cardiology;

—A little Port or Sherry at bedtime is a valuable relaxant to the insomniac and may obviate the need for sedative medication.

And wine can help brighten the often unappealing character of special or restricted dietaries—a psychological boost of inestimable value to the debilitated and depressed patient.

We believe you will find "Uses of Wine in Medical Practice" a valuable addition to your files. A copy is available to you at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

**Georges Ray, Vins de France, Paris, University Press, 1946 (p. 75).*

(Continued from Page 1526)

committee on Trauma of the American College of Surgeons and the Wayne Medical School.

Dr. Vernon C. Abbott of Pontiac presided over the conference.

This Trauma symposium was divided into two groups of illustrated talks on the surgical care of the injured. Then, ward-walk demonstrations were held in the Farwell Annex of Detroit's Receiving Hospital to coincide with subject matter presented during the lectures.

A welcome by Dr. Gordon H. Scott, dean of Wayne's College of Medicine, was followed. Lecturers: Dr. Herbert J. Bloom, "Care of the Fractured Jaw"; Dr. Joseph M. Caputo, "Treatment of Cord Bladder"; Dr. Harold W. Woughter, "The Fractured Hand"; Dr. Lyndon E. Lee, Jr., "Colostomy in Injuries of the Colon"; Dr. John E. Webster, "Fat Embolism"; Dr. Sidney Charnas, "Fracture of the Head and Neck of the Humerus"; Dr. Alexander P. Markey, "Acoustic Trauma"; Dr. Charles W. Peabody, "Trauma to the Knee Joint"; Dr. George L. Walker, "Management of Abdominal Distension"; Dr. Jack H. Hertzler, "Esophageal Trauma in Children"; Dr. A. Jackson Day, "Injuries of the Cervical Spine"; Dr. Nicholas S. Gimbel, "The Problem of Debridement of Burn Surfaces"; Dr. Emerick Szilagyi, "Injuries to Major Arteries and their Treatment"; Dr. Albert D. Ruedemann, "Principles of Treatment in Eye Injuries."

Guest Lecturer, Edward S. Piggins, commissioner of Detroit's police department, spoke on "Accidents—Their Prevention and Treatment from the Police Point of View."

* * *

Midwinter Seminar.—The Tenth Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 16, 1956. The lectures on ophthalmology will be presented on January 16, 17 and 18, and those on otolaryngology on January 19, 20 and 21. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 18, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p.m. on Wednesday. The schedule has been arranged to provide a maximum time for recreation each afternoon.

The Seminar lecturers on Ophthalmology this year are: Dr. Francis H. Adler, Philadelphia; Dr. A. Gerard DeVoe, New York; Dr. Michael J. Hogan, San Francisco; Dr. C. Wilbur Rucker, Rochester, Minnesota; and Dr. A. D. Ruedemann, Detroit, Michigan. Those lecturing on Otolaryngology are: Dr. Frederick A. Figi, Rochester, Minnesota; Dr. Lewis F. Morrison, San Francisco; Dr. Charles E. Kinney, Cleveland; Dr. John R. Lindsay, Chicago; and Dr. Bernard J. McMahon, St. Louis.

* * *

New officers of the Michigan Allergy Society are President, Sidney Friedlaender, M.D., Detroit; Vice

(Continued on Page 1530)

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President, Kenneth Mathews, M.D., Ann Arbor; and Secretary-Treasurer, E. Oskar Schreiber, M.D., Flint.

The Executive Committee is composed of Sidney Friedlaender, M.D., Detroit; Kenneth Mathews, M.D., Ann Arbor; E. O. Schreiber, M.D., Flint; Alex S. Friedlaender, M.D., Detroit; Henry Beale, M.D., Toledo, Ohio; Joseph Shaffer, M.D., Detroit.

* * *

Claire L. Straith, M.D., and **Burns G. Newby,** M.D., Detroit, had a scientific exhibit at the annual meeting of the Indiana State Medical Society, held at French Lick Springs, Indiana, October 16-20. The subject of the exhibit was "Oral, Plastic and Hand Surgery."

Dr. Straith was also the speaker there on two occasions on the subjects, "Reconstructive Surgery in the Severely Burned Patient," and "The Treatment of Maxillofacial Injuries in Traffic Accidents."

* * *

Pan American Medical Women's Alliance.—The V Congress of Pan American Medical Women's Alliance will meet at Santiago and Vina del Mar, Chile, on March 6 to 13, 1956.

* * *

Radioactive Waste.—The peacetime disposal of radioactive waste is as crucial a problem as personal protection against fall-out created by wartime atomic bombs, declared Dr. Charles W. Shilling of the U. S. Atomic Energy Commission, Wednesday evening, November 2, 1955, at the University of Michigan.

Dr. Shilling, deputy director of the AEC's Division of Biology and Medicine, spoke before the opening session of a three-day training course on radioactive liquid wastes sponsored by the U-M School of Public Health.

He said that by the year 2000 some 41 tons of fission products will be generated in atomic reactors annually.

Since these products at present are either dissolved or suspended in liquid, anywhere from 50,000 to 500,000 gallons of radioactive liquid waste will have to be flushed down the drain per day.

"The question is what drain?" asked Dr. Shilling.

Streams and rivers have been used for other types of sewage and might be suitable for radioactive materials of low level, he declared.

But he estimated that some of the "hotter" isotopes might take as long as 600 years to decay or weaken to a point where they might safely be dumped into a drinking source.

Among the several atomic "dumps" now being considered for radioactive waste products are the following:

1. Caves, abandoned mines, underground caverns.

2. Burying the material in sealed containers at the bottom of the sea.

3. If in gas form and at sufficiently low-level intensity, simple release into the atmosphere. If of high intensity, the gas could be compressed, stored, and later released.

4. Radioactive liquids, again if of low intensity, could be dumped safely into streams and rivers. If too active,

(Continued on Page 1532)

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the liquid might either be evaporated for more convenient storage, or stored directly in tanks.

5. Solids contaminated by radiation might be burned, the ashes stored until activity subsides, and then dumped into streams.

Studies are under way to make the discarded radioactive material suitable for secondary uses, in a manner similar to the gardener's use of garbage for compost.

He suggested that radioactive material, no longer suitable for science, might be used as fuel in heating homes; that low-level material might sterilize foods and drugs; and activated materials could be a replacement for the x-ray in treating diseases.

"I caution against an emotional approach to this whole problem of radioactive wastes."

He concluded that every precaution is being taken by the AEC in outlining complete specifications for protection against radiation, and that sanitary engineers and public health officials are studying ways of handling the atomic age's pollution problem.

* * *

Survey of Ophthalmology.—Drs. Harold F. Falls and John W. Henderson, of Ann Arbor, and H. Saul Sugar, of Detroit, have been named section editors for the *Survey of Ophthalmology*, a new bimonthly journal which makes its debut in February, 1956.

The journal, which will survey the world's current ophthalmologic literature with critical appraisals by the section editors, is under the editorial direction of Dr. Frank W. Newell, Chairman, Section of Ophthalmology, University of Chicago. It is to be published by The Williams & Wilkins Company of Baltimore.

* * *

Lahey Medical Education Award.—Former President Herbert Hoover has been given the Frank H. Lahey Award for outstanding leadership in medical education. President Eisenhower was the recipient of the first award last year. Mr. Hoover has served as honorary chairman of the National Fund for Medical Education since its formation. The award is sponsored by the American Medical Association, the Association of American Medical Colleges and the Fund. In accepting the award, Mr. Hoover reminded laymen and industry that it was up to them to find the funds to accommodate more pre-medical students in medical schools.

* * *

Guarding the Worker's Health.—Ways of keeping the American worker healthy and on the job will be considered by representatives of labor, management, government and the medical profession at the sixteenth annual Congress on Industrial Health, Monday and Tuesday, January 23-24, 1956, at the Sheraton-Cadillac Hotel, Detroit. Sponsored by the AMA's Council on Industrial Health, the sessions on Monday will be devoted to "The

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Role of Medicine in Industrial Relations" and "Medicine's Responsibilities in the Automotive Age."

A special all-day program on Tuesday will be built around the subject, "Absence from Work Due to Non-Occupational Illness and Injury," with particular reference to integration between industrial and private physicians. This program—arranged by the AMA's Committee on Medical Care for Industrial Workers—will cover such aspects as the nature and extent of the problem, efforts of management, labor and the community to reduce job absence, the role of various persons (for example, the worker, personnel director, nurse, doctor) in this field, and a discussion of the Ontario System of recording absence data.—*AMA News Notes.*

* * *

The March of Dimes.—The National Foundation for Infantile Paralysis is asking for $47,600,000 to continue its programs for 1956. Care and medication are needed in addition to further work on the Salk vaccine. Further research, iron lungs, and long continued nursing and medical care are still uprovided. The campaign will extend from January 3, 1956, to January 31, 1956.

The Future of Pharmacy.—Ten years from now the ethical pharmaceutical market in the United States should total around $1,650,000,000 annually, representing an increase of more than $650,000,000 over the present market, Eugene N. Beasley, the president of Eli Lilly and Company predicted, addressing the convention of the National Wholesale Druggists Association in White Sulphur Springs, West Virginia.

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He said his prediction is based on an expected 27,000,000 increase in United States population in the next decade and on the prediction of economists that total disposable income (income after taxes) will go up $113,000,000,000 in the same period to a total of $380,000,000,000.

Although medical research in the last fifteen years has brought new and lifesaving drugs and medicinal preparations, Beesley said, the American people now are spending one-fourth less of their total disposable income for medication than they did in 1939. The 1954 figure was 0.64 per cent of disposable income as compared to 0.87 per cent in 1939.

Beesley brought out that the antibiotics and "other so-called high-priced 'miracle' drugs" not only have helped prolong life and improve health but in some instances have conferred important economic benefits.

As an example, he cited a hospital statement that the average duration of treatment for tuberculosis in that institution was reduced from 733 days in 1951 to 170 days in 1953 following the advent of three new drugs—dihydrostreptomycin, PAS, and INH.

"It is not unusual now to hear of the closing of a tuberculosis hospital because of the decrease in the number of patients. Obviously, there has been substantial progress made in the treatment of tuberculosis, and this is merely one of the many examples that could be cited."

* * *

A Genealogical Chart of Dr. William Beaumont has been presented by Wyeth Laboratories of Radnor, Pennsylvania, to the Michigan State Medical Society for a place in the Beaumont Memorial at Mackinac Island. The chart was forwarded to Beaumont Memorial Committee Chairman Otto O. Beck, M.D., of Birmingham, by D. J. Withington, Director of Promotion of Wyeth.

Thanks were extended to Wyeth and Mr. Withington for their generous actions in continually sending important historical objects for inclusion in the Beaumont Memorial.

* * *

The diagnosis of active pulmonary tuberculosis is not a simple decision and may be equally troublesome for the family physician and for the medical specialist. This is true when tuberculosis is the only disease to be considered. How much more perplexing is the problem when the disease occurs in the course of other long-term illnesses.—ABRAHAM GELPERIN, M.D., Dr. P.H., LEON J. GALINSKY, M.D., and ALBERT P. ISKRANT, M.D., Public Health Reports, August, 1955.

* * *

Thomas H. Alphin, M.D. became Director of the AMA Washington Office on November 1, succeeding Frank E. Wilson, M.D., who resigned to become Executive Vice President and Secretary of the newly created Joint Blood Council, 1832 M. Street, N.W., Washington, D. C.

MEDICAL TELEVISION SHOWS

Produced by Michigan Health Council

DATE	*STATION*	*SUBJECT*	*GUESTS*
October 2, 1955	WJBK-TV, Detroit	Artificial Respiration	A Film
October 6, 1955	*WKAR-TV, East Lansing*	Michigan's Hospitals	Allan Barth, Lansing
October 9, 1955	WJBK-TV, Detroit	Arteriosclerosis	A Film
October 13, 1955	*WKAR-TV, East Lansing*	Sanitation	Philip Shirley, Lansing
October 16, 1955	WJBK-TV, Detroit	Dieting	A.E. Schiller, M.D., Detroit
October 20, 1955	*WKAR-TV, East Lansing*	Michigan's Men of Medicine	L. Fernald Foster, M.D., Bay City
October 23, 1955	WJBK-TV, Detroit	Infant Care	Ruth M. Kraft, M.D., Detroit
October 27, 1955	*WKAR-TV, East Lansing*	The Picture of Health	M. H. C. Film
October 30, 1955	WJBK-TV, Detroit	Peptic Ulcers	Glenn E. Millard, M.D., Detroit

* * *

Charles P. Doyle, M.D., of Lansing, was honored at the October meeting of the Ingham County Medical Society for his nearly sixty years of continuous private practice and service to his community. Dr. Doyle still maintains an active practice.

A graduate of the University of Michigan Medical School in 1896, Dr. Doyle has practiced in Lansing since his discharge from the Army in 1918, following World War I. Before his army service he was in Remus and Frankfort, Michigan. Both of his sons are professional men, Maurice J., a dentist in Lansing, and Charles R., a surgeon in St. Louis, Missouri.

Dr. Doyle is an emeritus member of MSMS, and a charter member of the MSMS "Fifty-Year Club."

* * *

Carl M. Peterson.—MSMS members and colleagues throughout the nation, were shocked by news of the death of Carl M. Peterson, M.D., fifty-five-year-old secretary of the AMA Council on Industrial Medicine, from injuries suffered in the flaming crash of a private airplane at Asheville, N. C., September 26. Dr. Peterson was widely known among MSMS members practicing in the field of industrial medicine. Many of his close friends left remembrances to the "Carl M. Peterson Memorial Fund" which is to be used for graduate scholarships in industrial medicine.

* * *

C. Paul Hodgkinson, M.D., Detroit, **John G. Rukavina, M.D.**, Ann Arbor, and **Claire L. Straith, M.D.**, Detroit were guest speakers at the 106th Annual Convention of the Indiana State Medical Association, French Lick, October 16-19.

MOUNT CARMEL MERCY HOSPITAL

Seventeenth Annual Clinic Day

January 25, 1956

Morning Session—9:00 a.m.

L. EMMETT HOLT, JR., M.D.
Professor of Pediatrics, New York University College of Medicine, New York, N. Y.
"Observations on Intestinal Intolerance"

FRANK GLENN, M.D.
Professor of Surgery, Cornell University, Ithaca, N. Y.
"Recent Advances in Diagnosis and Treatment of Biliary Tract Disease"

RICHARD B. CATTELL, M.D.
Lahey Clinic, Boston, Mass.
"Improvements in the Management of Cancer of the Large Intestine"

SHIELDS WARREN, M.D.
Professor of Pathology, Harvard Medical School, Boston, Mass.
"Medical Aspect of Radiation Fallout"

Luncheon—12:30 p.m.
Compliments of the Sisters of Mercy

Afternoon Session—1:45 p.m.

WALTER L. PALMER, M.D.
Professor of Medicine, University of Chicago, Chicago, Ill.
"Physiologic Considerations in the Problem of Peptic Ulcer"

GARFIELD G. DUNCAN, M.D.
Professor of Medicine, Jefferson Medical College, Philadelphia, Penn.
"Highlights in the Management of Diabetes"

VINCENT J. O'CONOR, M.D.
Professor of Urology, Northwestern University, Chicago, Ill.
"Present Status of Radioactive Isotopes in the Treatment of Carcinoma of the Prostate and Bladder"

CLYDE L. RANDALL, M.D.
Professor of Obstetrics and Gynecology, University of Buffalo School of Medicine, Buffalo, N. Y.
"The Early Detection of Gynecologic Malignancies"

Scientific Exhibits

"Primary Carcinoma of the Gallbladder"

LAWRENCE WM. GARDNER, M.D., Director of Laboratories, takes pleasure in presenting an exhibit on Primary Carcinoma of the Gallbladder, consisting of 36 Kodachrome Transparencies, illustrating the salient features of this disease, based upon 42 cases studied at our Institution, and a complete review of the literature.

"Congenital Leukemia"

JAMES G. WOLTER, M.D., Associate Director of Laboratories, will present a review of literature on Congenital Leukemia, with presentation of an additional case. Kodachrome Transparencies illustrate the gross and microscopic pathology, with hematological studies.

"New Approach to Treatment of Common and Refractory Gingivitis"

LEON HERSCHFUS, D.D.S. This exhibit is based upon a personal study of 26 cases of Gingivitis treated by Pfizer's Cortril, with Terramycin Dental Ointment.

"Research Committee Exhibit"

JAMES J. FRYFOGLE, M.D., will present the following phases of work:

1. Continuation studies on surgery of coronary heart disease.
2. Replacement of aortic segments, using homographs and plastic prosthesis.
3. Resection of the aortic arch, with replacement and physiologic experimental data.

Notation: The above project sponsored by the Michigan Heart Association.

Conducted tours of the Physiologic Laboratory and Experimental Surgical Laboratories will be held.

16th ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Sheraton-Cadillac Hotel, Detroit

January 23-24, 1956

Principal Speakers: ELMER HESS, M.D., President, American Medical Association
BENSON FORD, Vice President, Ford Motor Company

Jan. 23

9:30 a.m. "Occupational Medicine in Industrial Relations"

The contributions and failures of occupational medicine in industrial relations will be discussed by a physician, an industrial nurse, a labor referee, and representatives of employes and management.

2:00 p.m. "Medicine's Responsibilities in the Automotive Age"

An epidemiological approach to one of the greatest problems of our time—automobile accidents and injuries. Dr. Elmer Hess and other national authorities will discuss design deficiencies in modern passenger autos and trucks, driver licensing, physical examination of drivers and possible disqualifying disabilities.

7:00 p.m. ANNUAL DINNER

Mr. Benson Ford will address the banquet. The Annual Award will be made to a physician who has made an outstanding contribution to the Welfare and Employment of the Nation's Physically Handicapped.

Jan. 24

"Absence from Work Due to Nonoccupational Illness and Injury"

Four panel discussions on a problem of concern to labor, management, the community and medicine. Sponsored by the Committee on Medical Care for Industrial Workers. William A. Sawyer, M.D., Chairman.

Entire conference co-sponsored by: Council on Industrial Health, AMA, Wayne County Medical Society, Michigan State Medical Society, Michigan Industrial Medical Association, Detroit Industrial Physician's Club, Detroit Society for Surgery of Trauma.

Not only did the judge find no conspiracy, but he pointed out that the Spears' Institution is being operated illegally—based on evidence that chiropractors are on salary there, even Spears himself. According to George F. Lull, M.D., Secretary and General Manager of the American Medical Association, there is indication that this ruling, while it is appealable, may have significance in medicolegal circles in view of the current question of the practice of medicine by hospital corporations having radiologists and pathologists on their payroll.

The current case was the second legal setback suffered by chiropractor Spears in 1955; in March, Spears' suit against the Crowell-Collier Publishing Company, New York, was heard in Federal Court as a result of Spears' being named in a *Collier's* article entitled "Cancer Quacks"—May, 1951.

* * *

DOCTOR LOCATIONS
Through October 31, 1955

Placed by Michigan Health Council	*Opened Practice in*	*Approx. Date*
Dale Douglas, M.D.	Monroe	October 1
Robert C. Rood, M.D.	Morley	October 1
Assisted by Michigan Health Council		
A. J. Neerken, M.D.	Kalamazoo	September
Robert E. Rice, M.D.	Gaylord	October 1
Joseph Meadows, M.D.	Saginaw	October 15
Matthew Bick, M.D.	Mt. Pleasant	July

IDENTIFYING X-RAY FILMS

(Continued from Page 1467)

patient's or relative's signature and other data pertinent to the patient's film at the time of exposure is very important legally. It also saves the time necessary to mark the films properly after they have been dried.

Physicians, who are subpoenaed to court and are requested to identify x-ray films, will have little difficulty if the patient's signature appears on them.

DIGEST OF PROCEEDINGS NINETIETH ANNUAL MEETING

(Continued from Page 1518)

XIV—10. VICE SPEAKER

Nominations are now in order for Vice Speaker of the House of Delegates.

E. A. Osius, M.D.: I would like to place in nomination a man who does not need any introduction to you. In fact, he has had a trial run on several occasions, and has acquitted himself very credibly. I would like to nominate, to succeed himself, Dr. Kenneth Johnson of Lansing.

THE SPEAKER: I would like to second the nomination. It was seconded by several. Are there further nominations?

J. R. RODGER, M.D.: I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Johnson.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

K. H. JOHNSON, M.D.: When I looked over this agenda for tonight, I noticed that the last thing before adjournment was the election of a Vice Speaker of the House of Delegates. I think I shall use the next half hour giving a little speech. Maybe I can be prevailed upon to leave it for another time.

Thank you very much, gentlemen, for your vote of approval of what I have attempted to do. I will try to do my very best next year.

THE SPEAKER: It is quite hard each year to give proper credit for all the effort that goes into the proper functioning of the House of Delegates. First of all, I want to again thank Dr. Johnson for his great help behind the scenes, as well as at the microphone this year in helping the Speaker with the business of the House of Delegates.

Also, a lot of credit goes to our Secretary, Dr. Foster, and to the staff in Lansing, Mr. Burns, Mr. Brennaman and their associates, and the secretaries, all of whom have put a lot of effort into organizing this House of Delegates beforehand.

To the many committees, and especially their chairmen who put in a lot of extra work making the smooth functioning of the House possible, my thanks.

Thank you all.

This concludes the 90th session of the House of Delegates of the Michigan State Medical Society. We stand adjourned.

(The meeting adjourned sine die at 10:15 p.m.)

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

TEA. A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Henry J. Klaunberg, Ph.D., Editor; Executive Director, The Biological Sciences Foundation, Ltd.; Founder Member of the United States Committee of the World Medical Association; Member, The American Association for the Advancement of Science, The New York Academy of Sciences, The Biometric Society, American Medical Writer's Association, et cetera. Washington, D. C.: The Biological Sciences Foundation, Ltd., 1955. Price, $1.00.

This pamphlet consists of the papers presented at a conference of the New York Academy of Sciences, May 15, 1955. They were selected to organize research and clinical data on tea for use by dietitians, nutritionists and the medical profession. There are eight papers in this volume covering the pharmacology, the psychological and the psychophysiological effects as well as the medical and dietary aspects.

It is said that the beginning of tea as a beverage dates to 2700 B.C. A Chinese philosopher, Chin-nung, built a fire from the branches of the tea plant and some of the leaves accidentally fell into the boiling water. Whether this was the real beginning of tea drinking or not, one cannot deny that it has been a popular beverage for many centuries and that it has had considerable importance even in the Western World. Though not as popular a beverage in this country as coffee, the per capita consumption in 1954 was 0.69 pound as compared with 14.7 pounds for coffee. However, where one pound of coffee makes 40 cups, a pound of tea produces 200 cups. This would make consumption of tea about one third as great as the more popular coffee.

A matter of some interest in view of certain prejudices occasionally expressed, is the actual difference between green and black tea. This difference is the result of methods of preparation. Green tea results when the leaves after being dried for a short time in the sun are heated in open pans with constant agitation. For black tea, the dried leaves are rolled either between the hands or between two flat surfaces. This gives them their characteristic twisted shape and presses out some of the extractive material. While standing exposed to the air at 35 to 40 degrees Centigrade for about twelve hours, fermentation takes place and the leaf changes color. The result is that some of the aromatic property of the leaf is volatilized and a portion of the tannic acid is destroyed. This gives black tea a somewhat less fragrant odor and a less astringent taste.

The pharmacological effects of tea are those produced mainly by caffeine, though the tannins may contribute

an astringency to the gastrointestinal tract. When used as a beverage its values and effects seem more closely related to personal prejudices and habits. Some of these are discussed from a scientific viewpoint. On the whole, the book does provide a source of information of value to dietitians, nutritionists and other interested persons.

F. O. M.

TALKING WITH PATIENTS. By Brian Bird, M.D., Associate Professor of Psychiatry, Western Reserve University. Philadelphia and Montreal: J. B. Lippincott Company, 1955. Price $3.00.

Psychiatric and psychotherapeutic problems are noted with increasing frequency. They are found most commonly in the practices of the family physician, but are also noted in even the most restricted of specialties, and frequently are hidden by even very simple problems. The ability to talk with his patient will enable the doctor to evaluate the importance of the emotional aspects and will enable him to aid in the solution of many problems before they become serious.

The experienced and successful practitioner will find the counterparts of many of his patients in this little volume. He may also recall that with a little such help as this book provides, he might have avoided some of the distress he suffered in learning "The Art of Medicine."

The book is well written, easy to read, and has many short chapters. The first section deals with adults and has chapters entitled "The Angry Patient," "The Patient Who Cries" and "The Anxious Doctor." The second section deals with children and their fears of doctors, injections, anesthesia and the child's reaction to injury.

F. O. M.

INDUCED ABORTION ON PSYCHIATRIC GROUNDS. A Follow-up Study of 479 Women. By Martin Ekblad. Copenhagen: Ejnar Munksgaard, 1955.

This clinical and statistical study was undertaken in 1949 following a marked increase in the total number of legal abortions in Sweden. This increase followed a revision in the law, enacted in 1946, which permitted the granting of abortion for indications not previously included as medical. These indications, classed as "medical-social and social-medical" made up 60 per cent of the 5,889 abortions in 1950. As the indications in these categories had to do with the preservation of mental health and with the prevention of unfavorable mental sequalae, this psychiatric study and the follow-up was begun.

The work was carried out at the Psychiatric Clinic of Karolinska Institute and the clinical material was obtained from the Gynecological Department of the Sabbatsberg Hospital in Stockholm. The women included were all personally examined by the author prior to the operation. A follow-up study two and a half to three years later included an intelligence test as well as social, medical and psychiatric evaluation. The material was then classified with respect to civil status, age, heredity, childhood environment, schooling, history of sexual misdemeanours, occupation, the male partner, number of children, previous abortions, intellectual level and the presence of deviated personality, psychoneuroses

or psychoses. All of the 479 women in this particular study had been granted abortion on psychiatric, mixed psychiatric and social indication. In connection with the unwanted pregnancy, these women had developed a psychiatric reaction which, together with the previously manifested signs of mental illness, provided the basis for the legal abortion.

The results of the study are presented under a number of categories, such as: "Civil status and the woman's relation to the male partner"; "Relation of the legal-abortion clientele to the illegal-abortion clientele and the risk of suicide"; "Occurrence of new pregnancy after the abortion"; "Mental sequelae and self-reproaches on account of the abortion," and a number of others.

Among the conclusions arrived at, some are of sufficient interest to be presented here. The intellectual level of the women studied was approximately that calculated for the general population. However, 58 per cent of these women had manifested symptoms of chronic neurosis or abnormal personality even before the pregnancy in question, compared to a calculated frequency of about 15 per cent in the normal population. The risk of illegal abortion or suicide in the event of refusal of legal abortion is greater for the women who have been deserted by the male partner. Whereas 25 per cent had felt mild to serious self-reproaches following the abortion, 65 per cent had had no untoward reaction. Even in those instances when the subjective symptoms were severe, the psychiatric evaluation would class the disorder as mild. As might be expected the stress of a legal abortion was found to be greater in women who had suffered from pre-existing psychiatric disorder. The risk of unfavorable sequelae was also greater when the woman was influenced by others to submit to legal abortion.

The study is well supported by statistical tables and case histories. The table of contents is complete and detailed, permitting reference to any section or subsection without difficulty.

F.O.M.

THE PLASMA PROTEINS IN PREGNANCY. A Clinical Interpretation. By Harold C. Mack, M.D., Chief, Department of Obstetrics and Gynecology, Harper Hospital; Associate Clinical Professor, Obstetrics and Gynecology, College of Medicine, Wayne University; Senior Consultant in Obstetrics and Gynecology, Herman Kiefer Hospital; Associate in Gynecology, Detroit Receiving Hospital, Detroit, Michigan. Foreword by Nicholson J. Eastman, M.D. Springfield, Illinois; Charles C Thomas, 1955. Price, $3.75.

This 110-page monograph concerns the source, structure, function and amounts of the various albumins and globulins in the blood of pregnant women. Although the field is, as yet, not completely understood and is also rather complicated, the book is well written and understandable to the semi-scientific practitioner.

The author attempts to take the knowledge we already have gained about the plasma proteins in normal and in complicated pregnancies through the use of electro-

phoretic determinations and apply it to the physiologic and the pathologic processes that take place.

It seems apparent that the changes in plasma proteins which accompany the physiologic processes of reproduction are largely quantitative. Also, in "toxemias of pregnancy" this quantitative change seems exaggerated with no appreciable qualitative change. This would be added evidence against the "new toxin" theory in "toxemias of pregnancy."

The book is one which cannot be read through rapidly but must be carefully studied in order to apply its principles to the daily obstetric case.

S.T.L.

Membership of MSMS as of October 1, 1954 was 5,107 paying dues, 29 retired, 194 life and emeritus, 158 military, 131 associate and 2 honorary.

The same date in 1955 showed: 5,266 paying dues, 49 retired, 177 life and emeritus, 136 military, 299 associate, and 7 honorary.

The total in 1954 was 5,623 and in 1955, 5,934.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty.

M.D. NEEDED at once for small clinic for outpatient service in Northern Michigan community; population including summer residents approximately 1250; 200 employed in single industry. Clinic equipped, x-ray, has graduate nurse. Nearest doctor 35 miles; hospital 60 miles. Locum tenens December 1 to May 1 or permanent basis. Will try to meet income requirements. Reply Box 7, 606 Townsend Street, Lansing 15, Michigan.

EAST LANSING: New four-unit, modern, air conditioned, medical building located just across the campus from Michigan State University. One suite of five rooms still available for physician. Write or call Hicks Bros. Realty Co., 313 E. Grand River Avenue, East Lansing, or phone EDgewood 2-3011.

PHYSICIAN WANTED: Excellent location for the right doctor to do private general practice independently, with the possibility of associate relations with established surgeon. A well-equipped and staffed 50-bed hospital located in Michigan, below the Straits, is available to the community. Write: Box 4, 606 Townsend St., Lansing, Michigan.

PHYSICIAN WANTED: Salary, $11,985.12 to $14,031.36. To have charge of state-wide Adult Health Section of the Michigan Department of Health, to plan special projects, direct educational activities, and conduct such control programs as are possible for cancer, diabetes, rheumatic fever and other diseases prevalent among the adult population. Physician desired with active interest in public health—plus practice in internal medicine or actual public health experience. Apply Mr. R. J. Murray, Michigan Department of Health, Lansing 4, Michigan.

GENERAL SURGEON, completing surgical residency on December 31, 1955, at a University Hospital, desires association with surgeon. Board-eligible. Veteran. Married. Age, thirty-one. Write Box No. 8, 606 Townsend Street, Lansing 15, Michigan.

GENERAL PRACTICE RESIDENCIES available for one or two years at fully accredited modern hospital. Excellent opportunity, liberal salary and maintenance. American or Canadian medical school graduate preferred. Contact Mr. Title, Brent General Hospital, 16260 Dexter, Detroit, Michigan. Telephone DIamond 1-2990.

WANTED: Middle-aged physician for full-time duty, out-patient department of small hospital. Some house calls. Also, desire internist. Salary and commission open. Reply Box 10, 606 Townsend Street, Lansing 15, Michigan.

FOR SALE: Hospital, 12 beds, modern, brick construction, new 1941. Clinic facilities. Owner has land adjacent for expansion. Good location, near Detroit, Michigan. Reply Box 9, 606 Townsend Street, Lansing 15, Michigan.

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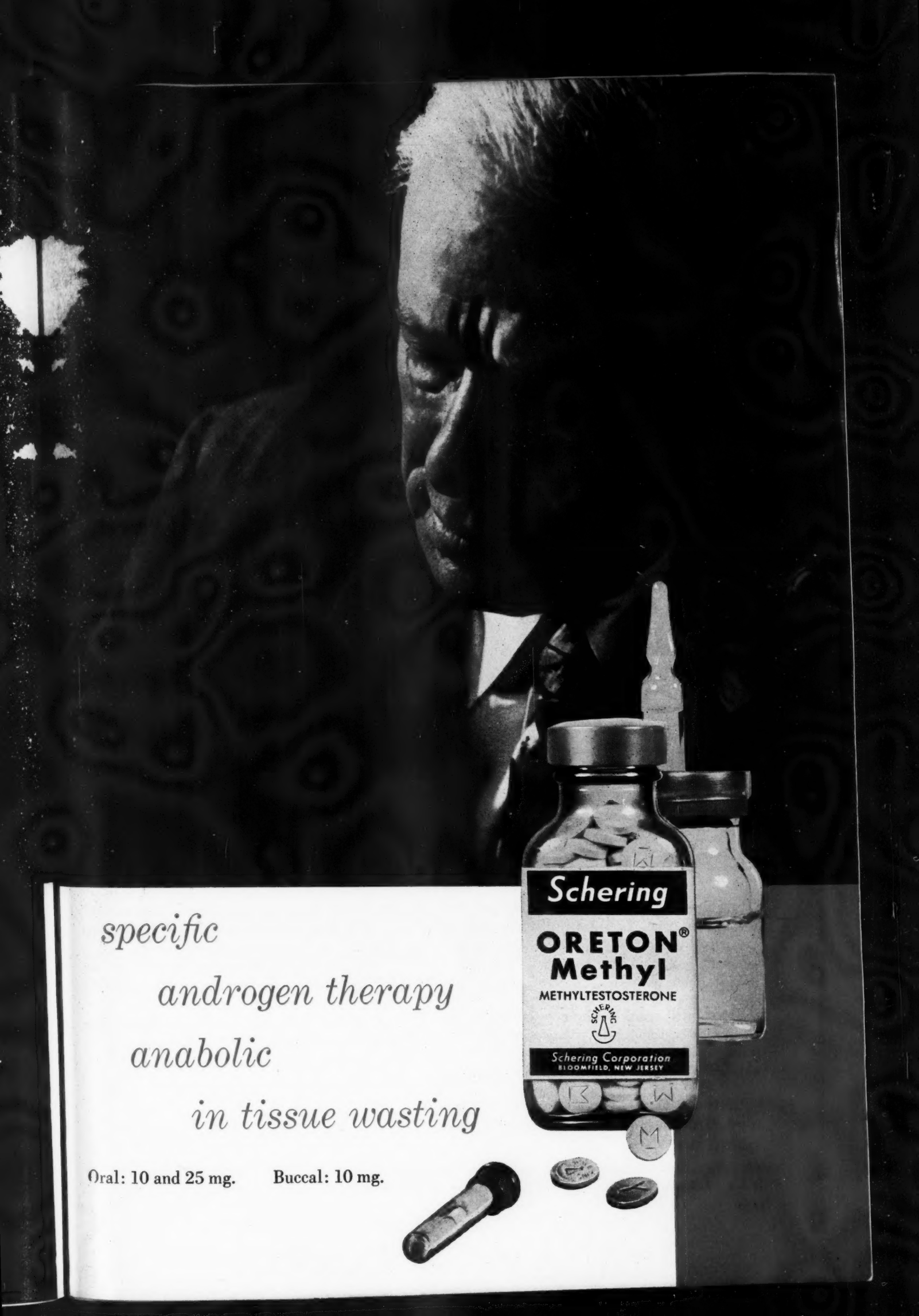

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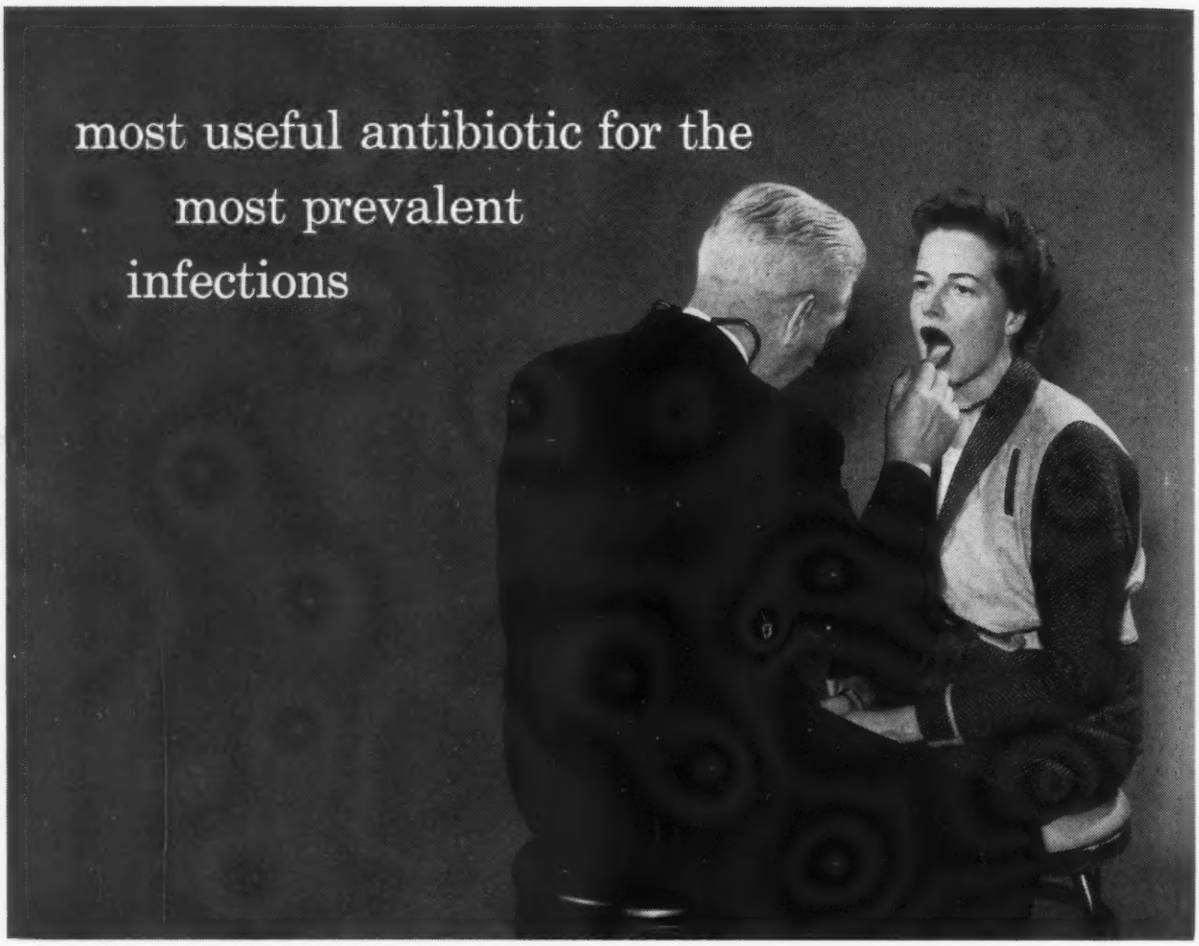

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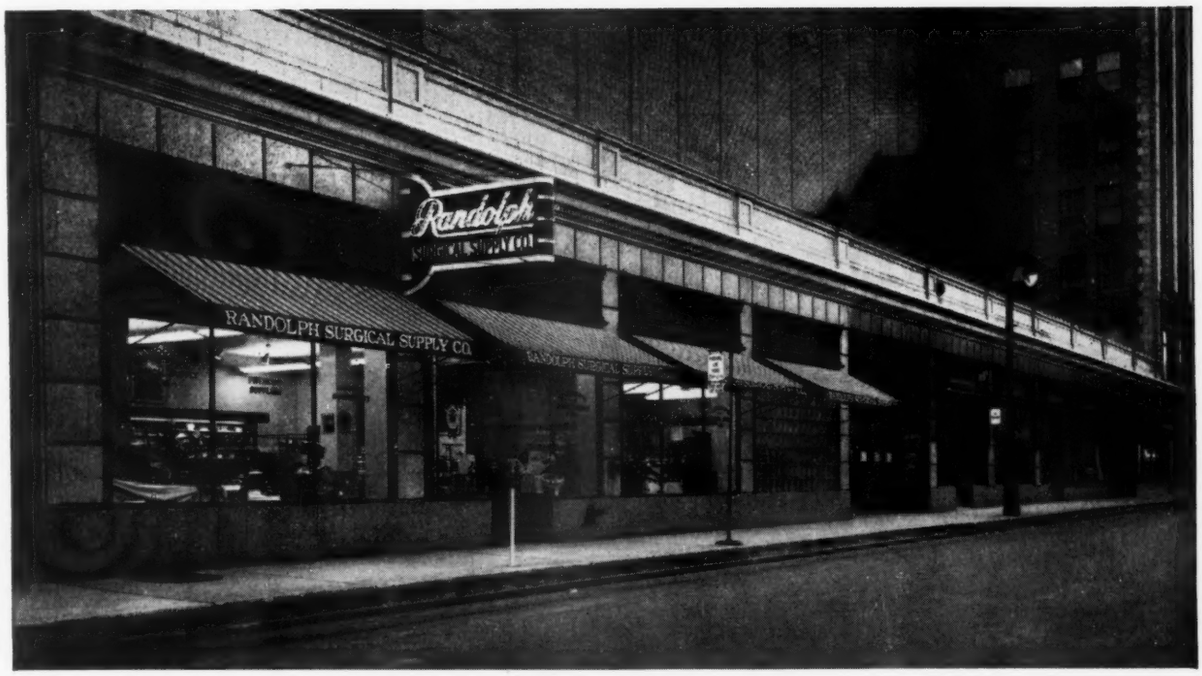

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